SHC Rapkyns Group Limited

The Laurels

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?	**Good**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 10 May and was unannounced.

The Laurels provides accommodation in four units called Birch Lodge, Juniper Lodge, Cherry Lodge and Aspen Lodge, which are all on one site. The Laurels provides nursing and personal care for up to 41 people who may have learning disabilities, physical disabilities and sensory impairments. At the time of our inspection there were 36 people living at The Laurels.

People living at the service had their own bedroom and en-suite bathroom. In each unit, there was a communal lounge and separate dining room on the ground floor, where people could socialise and eat their meals if they wish. The units shared transport for access to the community and offered the use of specialist baths, spa pool, physiotherapy, weekly GP visits, 24-hour nurse support, multi-sensory room, social and recreational activities programme and a swimming pool. The service had a gym, which offered exercise equipment and had been developed by the physiotherapists employed by the provider. There was a room allocated for using computers. This was a space for people to contact their relatives through Skype, Facebook and email. The service could accommodate relatives who wished to visit their family.

The service had a registered manager but at the time of the inspection, this person was no longer managing the service on day to day basis. A home manager was appointed in January 2017 and had submitted an application to register. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who 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 home manager was not available on the day of inspection. The registered manager, although regularly based at the service, was working as an area manager for the provider. Following the inspection we met with the provider who informed us the home manager had left SHC Rapkyns Group Limited. The nominated individual confirmed that the registered manager who had been promoted to area manager had returned to the Laurels as the registered manager, in day to day charge.

The inspection was bought forward as we had been made aware that following the identification of significant risks relating to people's care, the service had been subject to a period of increased monitoring and support by commissioners. The service had been the subject of eight safeguarding investigations by social services. Following the inspection, we received assurances from the Clinical Commissioning Group (CCG) that they had also visited the service and risks relating to safeguarding concerns they were investigating had improved. They offered assurances that care plans relating to some of those people had improved and their needs were being met. However, despite these improvements and measures being in place, we identified a number of further risks, which were not appropriately managed and found four breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. At the last inspection in April 2016, the service was found to be compliant with our regulations and was given a rating of 'Good.'

Individual risks relating to people's health and welfare were not always identified and assessed to reduce those risks. Risk assessments were not always in place to provide detailed guidance to staff in how to protect people from harm. Incidents and accidents were not analysed effectively to learn lessons and reduce the likelihood of them happening again.

Staff had received safeguarding training, demonstrated an understanding of key types of abuse and explained the action they would take if they identified any concerns. However, whilst some incidents had been reported, other incidents, such as verbal abuse, intimidation and physical abuse between people, had not been identified as safeguarding concerns and had not been reported to the local authority safeguarding agency or to the Care Quality Commission as required by law.

The Deprivation of Liberty Safeguards (DoLS) protects the rights of people ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Staff had received training with regard to the Mental Capacity Act 2005 and DoLS. Staff had a good understanding of the Mental Capacity Act 2005 (MCA); however, this was not always demonstrated when best interest decisions had been made for people who were deemed to lack capacity.

Previous robust systems of audit and control had not been continued and had led to a lack of managerial oversight and the failings identified during this inspection. On the day of the inspection the area manager failed to provide us with the essential records to complete the inspection. The area manager told us he lacked the knowledge of where records were kept within the service, and therefore was not forthcoming with providing the information we requested for the inspection. Consequently, we requested a number of records to be emailed to us following the inspection. This included records of complaints and how complaints had been managed. However, we never received that information. Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured a consistent high quality service across the service or pro-actively identified all the issues we found during the inspection.

The provider had failed to display their ratings on the website which we discussed with the area manager on the day of inspection. Following the inspection the rating is now displayed.

The provider had not notified the Care Quality Commission of incidents which they needed to tell us about.

Staff we spoke with gave us mixed opinions about the current management arrangements, vision, values and culture of the service.

There were sufficient staff in place to meet people's needs. However, we have made a recommendation regarding how staff are deployed to safely and effectively meet people's individual needs. The provider used a dependency tool to assess that staffing levels were based on people's needs. These were up to date and reviewed monthly. Robust recruitment practices ensured that new staff were vetted appropriately and checks were undertaken to confirm they were safe to work in a caring profession.

Policies and procedures were in place and medicines were managed, stored, given to people as prescribed and disposed of safely. Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing.

Staff received an induction into the service and the home manager checked competencies in a range of areas. Staff had received a range of training and many had achieved or were working towards a National Vocational Qualification (NVQ) or more recently Health and Social Care Diplomas (HSCD). Staff were able to pursue additional training which helped them to improve the care they provided to people. We saw that

some staff had not received support and supervision in line with the company policy. However, the staff told us they felt they supported each other well and found the provider approachable and supportive.

At this inspection, people described staff as kind and caring. People told us they felt they were treated with respect and dignity. Our observations reflected this. The home had been decorated and arranged in a way that supported people living with complex needs.

People enjoyed the meals at the service and were offered choice and flexibility in the menu. The chef had a good understanding of people's likes and dislikes and took great care to provide specific dishes or supplies to meet people's requests. People had access to a range of healthcare professionals and services. People's rooms were decorated in line with their personal preferences. The premises were purpose built and provided space for people to move around freely, to relax and to enjoy outdoor spaces.

People were involved in planning and reviewing their care as much as they could, for example in deciding smaller choices such as what drink they would like or what clothes to choose. Where people required more time to make choices, staff were patient in repeating choices each time and explaining what was going on and listening to people's responses. Staff had a good knowledge of people, including their needs and preferences. Care plans were personalised to reflect people's needs, choices and preferences.

People's privacy was respected. Staff ensured people kept in touch with family and friends. People were able to see their visitors in communal areas or in private. The service provided support for people's emotional well-being through the provision of meaningful social activities and opportunities. People were offered a wide range of both group and individual activities that were meaningful to them and which met their needs and preferences.

People and their relatives were involved in developing the service through meetings. People and their relatives were asked for their feedback in annual surveys.

At this inspection, we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. We also found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Individual risks to people had not always been assessed and action had not been taken to minimise the likelihood of harm.

Staff had been trained in safeguarding vulnerable adults. However, we found there had been incidents which had not been recognised as safeguarding concerns which had not been appropriately reported.

There were sufficient numbers of staff to make sure that people were safe and their needs were met. However, we made a recommendation of how staff were deployed to safely meet people's needs.

Medicines were managed in accordance with best-practice guidelines.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to consent to care and treatment was not always properly assessed and recorded to determine people's level of understanding in accordance with MCA.

Staff were trained in a range of topics, which were relevant to the specific needs of the people living at the home.

People were supported to maintain good health and had regular contact with health care professionals.

People were provided with a balanced diet and had ready access to food and drinks.

The environment was conducive to meeting the needs of people with complex needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took time to speak and listen to them.

People were supported to maintain their privacy. Staff knew how to communicate with people in an accessible way, according to their individual needs, so they could understand their choices and decisions.

People were consulted about their care and had opportunities to maintain and develop their independence.

Is the service responsive?

Good

The service was not always responsive.

We were unable to assess how the home manager responded to complaints, as they were unable to provide us with complaint records when requested.

People received a personalised service that was responsive to their changing needs. Care plans provided information to staff about people's care needs, their likes, dislikes and preferences. Staff understood the concept of person-centred care and put this into practice when looking after people.

There were structured and meaningful activities for people to take part in.

Is the service well-led?

Inadequate

The service was not well led.

The service is required by a condition of its registration to have a registered manager. We found that the provider had not taken satisfactory steps to comply with this condition of their registration.

The provider had failed to display their ratings on the website.

The provider had not notified the Care Quality Commission of incidents which they needed to tell us about.

Previous systems of audit and control had not been continued and had led to a lack of managerial oversight and the failings identified during this inspection. On the day of the inspection the area manager failed to provide us with the essential records to complete the inspection.

Systems were in place to assess, monitor and improve the

service but these were not being operated effectively as they had not prevented the breaches of regulation we identified from occurring.

The Laurels

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 took place on 10 May 2017 and was unannounced. The inspection team consisted of two inspectors and a specialist nurse advisor.

Before the inspection, we reviewed records held by CQC, which included notifications and other correspondence. A notification is information about important events, which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We also contacted health care professionals and two funding authorities to seek their views.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We did however; spend time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks; we observed their care, including the lunchtime meal in Juniper and Cherry lodges, medicines administration and activities. This helped us understand the experience of people who used the service. We looked around the premises at the communal areas of the home, activity areas and six people's bedrooms.

We spoke with five people who lived at the service, the nominated individual, head of quality and therapies, the clinical lead and the registered manager who was also the area manager. We spoke to the deputy manager who was also a nurse, one other nurse, two senior care assistants, one care assistant and one agency care assistant. We also spoke to one visiting professional for their views on the service, who was a general practitioner [GP].

We looked at the care plans and associated records for six people. We looked at seven people's medication records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, health and safety checks. Records for six staff were reviewed, which included checks on newly appointed staff and staff supervision

records.

Requires Improvement

Is the service safe?

Our findings

The inspection was bought forward as we had been made aware that following the identification of significant risks relating to people's care, the service had been subject to a period of increased monitoring and support by commissioners. The service had been the subject of eight safeguarding investigations by social services. Following the inspection, we received assurances from the Clinical Commissioning Group (CCG) that they had also visited the service and risks relating to safeguarding concerns they were investigating had improved. They offered assurances that care plans relating to some of those people had improved and their needs were being met. However, despite these improvements and measures being in place, we identified a number of further risks, which were not appropriately managed that related to the care of some people.

The provider had safeguarding policies and procedures in place to guide practice. Safeguarding procedures were designed to protect people from the risk of abuse and neglect. All staff had undertaken training in safeguarding adults and mostly demonstrated they were aware of their role and responsibilities keeping people safe by reporting any concerns. One member of staff told us, "I would inform line manager, if not going anywhere go higher. I would whistle blow as well if needed." Another staff member told us, "I would report to manager, someone with responsibility and do a statement." We asked what the staff member would do if the manager did not respond, the staff member told us, "I think I could go to a higher manager. I could contact area manager." However, the staff member stated they did not know they could contact social services or CQC.

The home manager did not always take appropriate action in the event of possible safeguarding concerns and this may have placed people using the service at risk of unsafe care. For example, accident and incident forms we reviewed detailed seven incidents where the home manager should have raised a safeguarding alert with the local authority. In six incidents, a person using the service had been seen by staff physically assaulting other people who used the service. In one incident, care staff had recorded unexplained bruising on a person's arms. The home manager should have informed the local authority's safeguarding adult's team and the Care Quality Commission (CQC) of these possible safeguarding concerns. This would have enabled an independent investigation of the incidents to ensure people using the service were cared for safely.

For people who had been injured in these incidents and for one unexplained injury, body maps had not been completed detailing the injury and there was no evidence of these injuries being followed up on to ensure injuries had healed. We identified these to the area manager who was unable to provide an explanation to these.

The area manager confirmed they were not aware of these incidents and that no investigation had been completed to establish the cause. Whilst the home manager held a central file of accidents, incidents and safeguarding matters, the area manager stated he had not checked the files themselves as part of their auditing process and had relied on information given to him by the home manager.

Following the inspection, we spoke with the local authority safeguarding team about these and other incidents we had identified at our inspection. They confirmed they had not been made aware of six of the seven incidents by the home manager or staff. Following this discussion, CQC made seven safeguarding referrals to the safeguarding team as part of our duty to keep people safe from harm.

The provider failed to ensure systems and processes enabled appropriate investigation of potential safeguarding issues, which placed people at risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2014.

The majority of the incidents involving people being harmed involved the same person who also lived at the service. Following the inspection the nominated individual provided additional evidence that demonstrated they recognised they were unable to meet the person's needs. The nominated individual provided evidence of measures taken to support the person by making referrals to healthcare professionals for their specialist input. However, ultimately the provider supported the person to find an alternative placement that could better meet their needs. This was to ensure the person and other people remained safe. During the inspection the area manager told us people were safe because the person whose needs had deteriorated was no longer living at the service. The area manager gave assurances there were no other people living at the service posed who posed a risk to other people. We asked staff how they were informed of changes in care as result of incidents and safeguarding, one member of staff told us, "We discuss with staff in multi-disciplinary teams, staff hand overs, staff meetings. There are several ways of keeping staff informed. In another Sussex Health Care service [SHC], there was learning from abuse situation that was shared with all SHC homes. We called an emergency staff meeting, issued policy about staff gender and personal care. We make sure there is enough female staff."

We found there were some assessments of risk for the use of a bath, hydrotherapy pool, the use of a SPA and a shower trolley for people with epilepsy; however, these were not specific and lacked clear detail and guidance. For example where it stated 'possible risks/hazards', one stated, '[person] has epilepsy', for another person it stated, '[person] has epilepsy and can be triggered when she is stressed', and for another person it stated 'I am prone for seizures'. The risk assessments for example failed to say that the person could drown or that they could incur an injury. They did not describe the type of seizure the person could have and what signs to look for. For the management of risks identified the guidance was vague, which could result in the risks not being appropriately supported. Instead, the risk assessment stated 'refer to my epilepsy protocol', which was in another section of the folder. Another risk assessment stated 'staff to support in the spa or pool and know [person] well.' The guidance for example failed to state what this support should be and when it was required. These risk assessments did not identify specific risks and there was a lack of explanation to the measures which were needed to ensure people were safe.

Many people had bedrails in place. However, there was no clear rationale within people's care plans to identify why bedrails were required. There were no risk assessments in place for the use of bedrails, which would identify any further risks such as entrapment. There was no additional evidence that the risks associated with these had been fully explored. The documentation for people who had bedrails did not show that the least restrictive options had been considered or discounted before bedrails were put in place. We raised these concerns with the area manager at the time of the inspection, who said they would take action to ensure all risk assessments were implemented where assessed as needed and contained all of the relevant information needed to make sure people received safe care. The area manager told us that there was an orange cord to pull in an emergency when the hydro pool is in use, and that cushions are kept in bathrooms to make people comfortable if they are having a seizure in the bath, which minimises the risk of people being injured. However, we found that this was not mentioned in the risk assessments. We looked at the incident and accident records which indicated people had not been harmed or injured as a result of the

lack of information in people's risk assessments. Following the inspection the area manager wrote to us confirming everyone's risk assessments would be reviewed and updated by July 2017. Therefore this was an identified area for improvement.

Many aspects of risk management were being managed appropriately. Moving and handling risk assessments were reviewed regularly and changes implemented where necessary. These risk assessments described the number of staff needed and what equipment was needed for each movement and we saw that this was being followed. These were clearly written and contained step by step instructions with photographs to aid understanding of precisely how the person needed to be supported. Other assessments included the risk of choking and those at risk of malnutrition. Each person requiring suction of upper airway secretions had a protocol for when and how this should be done and which staff (trained in this technique) were able to do so. One person was identified as having a high risk of developing a chest infection and there was a care plan for a chest physiotherapy programme and positioning instructions with photographs as guidance for staff to follow. People who required tracheostomy care plans stated how often equipment should be changed, by whom and what the indications are for this to happen. There were instructions for how to raise concerns and seek support in an emergency and step by step guidance for care of the site. Tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help the person breathe.

We also found examples of risks being managed appropriately relating to the premises and equipment; these were monitored and checked to promote safety. For example, equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electric safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Fire equipment such as emergency lighting, extinguishers and alarms, were tested regularly by the provider's maintenance engineer to ensure they were in good working order. Records confirmed that maintenance staff attended immediately when contacted by staff to repair damage, which may cause harm to people and others visiting the service. People were protected from environmental risks within the service such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing.

We were told that people were free to move around the service and we observed this during our visit. We saw staff assisted people to go out on outings, for walks, or just to the dining room area to be able to participate in activities. Staff supported people to move around in a safe and reassuring way.

On the day of our inspection, we saw there were enough staff in sufficient numbers to keep people safe and the use of staff was effective. However, we observed one occasion when staff were not appropriately deployed to safely meet a person's needs. We observed an agency care worker providing one to one support to a person requiring supervision. The person was unsettled and as time progressed the person appeared to become more agitated, twice putting themselves on the floor and banging the floor, work surfaces and themselves. The agency member of staff was heard attempting to talk to the person and this was in a quiet and calm way but she did not appear to know how to support the person effectively. Forty five minutes later a permanent member of staff returned to the room and said that they would take over supporting the person. The agency staff member told us, "This is my second shift. I don't normally deal with [person] much." We asked what information she had been given about how to support the person, we were told, "I try to calm him down, it's very difficult. Today was really challenging for me. I was told to keep eye on him. I know he likes moving a lot, you have to be strong." We asked if there were any risks or medical conditions that she had been informed of and she replied, "Actually I have no idea." We asked if she had read the person's care plans and risk assessments and she replied, "No, it's something I have to do, it's really important as I didn't know how to deal with him and there was no one around to ask." We recommend the provider review the arrangements for how staff are deployed. The provider must ensure that staffing levels

have the right mix of skills, competencies, experience and knowledge, to safely and effectively meet people's individual needs.

For the remainder of the inspection we observed that there were sufficient staff on duty and that people received assistance and support when they needed it. If a member of staff had to leave the lounge they alerted another member of staff to ensure people were observed at all times. Staffing numbers were determined by a dependency tool, which considered people's level of need in areas such as mobility, nutrition and maintaining continence. These were up to date and reviewed monthly. Staffing could be changed if required, for example if people became particularly unwell. There were some people who lived at The Laurels who were supported on a one to one basis during the day and we saw adequate staff were on duty to ensure this was maintained. The staff rota showed there was a qualified nurse on duty at all times of the day and night. Shifts had been arranged to ensure that known absences were covered. The service had a 24 hour on call system in case of unforeseen events and if additional staff were needed. The recruitment and selection process ensured staff recruited had the right skills and experience to support the people who used the service. The staff files we looked at included relevant information, including evidence of Disclosure and Barring Service (DBS) checks and references. DBS checks helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Records showed checks were made that staff from overseas had the authority to work in the UK and that registered nurses were registered with the Nursing and Midwifery Council (NMC). Prospective staff underwent a practical assessment and role related interview before being appointed. This meant people were safe as they were cared for by staff whose suitability for their role had been assessed by the provider.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed the registered nurse administering medicines to people at lunchtime. Medication Administration Records (MAR) were clearly printed and each had photo identification of the person and any known allergies; there were also photos of each medicine. The registered nurse cross-referenced the medicine, dose and time with the information on the monitored dosage system blister packs. The medicines trolley was locked at all times when unattended. The registered nurse washed their hands between each administration of medicines and ensured that people had taken their medicines before signing the MAR. Medicines were stored in a locked drugs cabinet within a locked storage room. The registered nurse for each shift held the keys to the medicines storage room. A refrigerator dedicated to medicines storage was also in the room. The fridge temperature and room temperature were within recommended ranges to ensure the efficacy of the medicines; daily checks were made and temperatures recorded. We checked a sample of the medicines and stock levels and found these matched the records kept.

A clinical nurse tutor administered medicines and their competency was checked by the provider. A medicines policy provided guidance to staff on the safe administration, handling, keeping, dispensing, recording and disposal of medicines. Specimen signatures were on file for staff who were permitted to administer medicines as a means of identifying their signatures. Clinical observations were undertaken by the registered nurse to monitor people's blood sugar, blood pressure and pulse rates which indicated whether a person should be given a particular medicine or not. The registered nurse had a good understanding of what each medicine was for and how often people had reviews of their medicines undertaken.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 they 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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments had not always been completed when people were deemed to lack capacity and a decision needed to be made concerning a person's wellbeing. Best interest decisions did not always include the appropriate professionals, advocates and relatives. For example, we saw for four people, no mental capacity assessment had been completed and the best interest decision had been made by the home manager and senior management, for the use of four small video monitors being used in people's bedrooms. It was not clear why this monitoring was required. Two care plans indicated (and we observed) that a video monitor was in use and the screen was kept in the corridor in order to monitor and respond to the person's epilepsy symptoms. The staff were to watch the person for any indicators of an epileptic episode using the monitor. We raised this with the area manager who could not offer an explanation. We could not see that the provider and home manager had considered their compliance with the Data Protection Act 1998, Mental Capacity Act 2005 and Human Rights Act 1998 to ensure people's privacy and the necessity of this video monitoring. It was unclear what they were trying to achieve by having it in place and whether less restrictive options had been considered.

For one person, no mental capacity assessment had been completed and the best interest decision had been made by the home manager for the use of a handling belt. We observed a person constantly attempting to drink from cups, jugs and taps, pacing around the communal lounge/dining area. As time progressed, the person appeared to become more agitated, twice putting themselves on the floor and banging the floor, work surfaces and themselves. As the person became more anxious the agency member of staff used a handling belt that was around the person's waist to pull him away from drinks. Handling belts are also known as transfer belts, which are used to assist people who can support their own weight, for example to help them stand up. They should not be used for pulling on a person, or as a method of restriction. A staff member told us, "I think staff try not to restrain. [Person] has a belt round him. People who don't know him try and pull him using this and this is not right. The belt is to guide to sit and to get up."

For many people, capacity regarding bed rails had not been considered for people. There were no formal assessments of capacity for people who were using bed rails and no evidence of decisions to use bed rails being made in the person's best interests if this was applicable. This meant that the decision for their use may not have been in the individual's best interest and proportionate to the risk of not having them in place. Staff had not recognised the potential impact on people or explored alternative and more suitable options.

DoLS only apply to people who lack capacity; therefore in order for a service to determine an application is needed they would have to assess their capacity to make decisions relating to this. For one person the home manager had applied for a DoLS without having completed a MCA for the use of wrist cuffs to restrict a person's movement while in bed for reasons of safety.

A health care professional told us, "It is of great concern that recommendations around the use of wrist cuffs and the need for a robust MCA process had not been undertaken. Apparently the care home had asked the GP to complete a capacity assessment and all that was completed was an assessment of capacity for all medical needs, which is not decision specific and unrelated to the restrictive intervention. I think this lack of action suggests a wider misunderstanding of the requirements of the MCA and poses a risk to other people living at the care home."

Failure to gain consent off people and where the person's may have lacked capacity, is not acting in accordance with the Mental Capacity Act 2005. This place's people at risk of have unnecessary control or restriction placed on them that was not necessarily proportionate with the assessed risk. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13.

We also saw examples of where appropriate DoLS applications had been made, and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. We saw good examples of documentation in people's care records which showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

Overall, our observations showed staff were confident and knew how to support people in the right way. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs. Records confirmed that staff had completed training in the MCA and had a good understanding of this topic. For example, staff confirmed that people were enabled to give consent to most decisions concerning their day-to-day support by using communication techniques individual to the person. A nurse was knowledgeable about the communication needs of the person and gaining consent to administer medicines. They said, "With anyone it's good manners to be respectful. [Person] is partially deaf so I stand close, touch her gently. [Person] then relaxes and holds her fingers out and that's her way of telling me she's ready for me to give medicine or to test blood sugar levels." We observed that the description given by the nurse reflected what we saw in practice. One staff member told us, "[Person] doesn't like getting up early so we respect that and stays in and has medication later. People have private time when they want, gender care preferences are respected. [Person] loves gardens so staff support to access. We offer choices of own clothes and what meals to eat."

Staff received training in a range of areas, which the provider had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, fire safety, health and safety, infection control, food hygiene and safeguarding. We spoke to the clinical lead whose role was to manage the training to ensure it met the needs of people living in the service. They told us that in response to recent safeguarding concerns referred to in the safe domain, all nurses were in the process of being trained in how to manage complications that can arise from having tracheotomy care and PEG regimes. Tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help a person breathe and percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall, most commonly to

provide a means of feeding. The target date for this was by the end of May 2017. We enquired that due to the level of concerns raised in response to these clinical needs, whether this training should not also be mandatory. Before the inspection ended, we were given assurances by the head of quality and therapies that this training would now be mandatory for all nurses to complete and would be ongoing. The impact of this means that when complications may arise in these areas, hospital admissions can be prevented and the person can receive the care they require in the comfort of their own space, by staff who know them well. In addition to the mandatory training, the provider had ensured specialised training was given to care staff to be able to meet the individual needs of people being supported. This included staff completing courses in nutrition and hydration, epilepsy and challenging behaviour. The clinical lead told us, "I love training; to pass on my skills is wonderful. It's important all staff attends, which is what the manager does." A staff member told us, "The best thing about the company is if you request further training they will support you to access this. It helps they have their own training academy."

Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard. All new staff were required to complete essential training; this was over a four-day period when they first started. New staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

Not all staff had received supervision sessions in line with the provider's policy, which stated staff should receive supervision three occasions a year. However, staff said that they were fully supported to undertake their roles and responsibilities. They received one to one supervision as well as group supervision if requested. One staff member told us, "I get enough support. Management are really quick to support." The area manager emailed us their audit tool, which demonstrated that supervisions were not being carried out as regularly as they should. The action plan was in place to ensure staff supervision was arranged.

People appeared to enjoy their meals. We observed the lunchtime in two of the lodges. A choice of juices was on the table and staff supported people to have their preferred drinks. The atmosphere was very calm, relaxed and staff took the time to chat with people. Lots of conversation, laugher and body language that indicated people enjoyed their meals and the social interaction that took place. There was current chart music on the TV and people appeared to enjoy this. A four week menu was in place that offered people a variety and choice of home cooked meals, desserts and snacks. People were served beef enchiladas (this reflected the menu on display) and some people chose salad as an alternative. Dessert was Bakewell tart and custard. Pureed meals were provided for people where required. Each food item was individually displayed on the plate in an effort to make it appealing for people. Some people did not receive their nutrition orally and were supported by registered nurses to deliver nutrition via a PEG feed. The type and volume of nutritional fluid was determined by the dietician and guidance was followed by staff. Staff monitored people's weight and took action if any concerns were identified. This included additional support with eating meals, fortifying food or providing low-calorie options and referrals to healthcare professionals such as the GP or Dietician.

Staff engaged with people and offered support where required. One person made a sound that the staff recognised and responded to by asking the person if they would prefer to sit somewhere else. The person indicated they would and the staff responded promptly by assisting them to sit at a different table. Another

person pulled a face and made a sound that a member of staff recognised as an indication the person was not enjoying their meal. An alternative was provided but the person again indicated they did not want this. A third alternative was provided that the person then ate and enjoyed. Staff offered support to people in a kind and considerate way. For example staff said the following to people, "Would you like some help?," "Can I lean you forward a little?," "Shall I get you your lunch?," and, "Would you like gravy." One member of staff sat next to the person they were assisting, placing food on their spoon and assisted them to eat at a pace that was not rushed. During this they offered encouragement such as "Well done" when they swallowed and took the time to wipe the person's mouth as they were unable to do this themselves. Another member of staff cut food up for another person and placed a plate guard around their plate and as a result the person was then able to eat independently. The member of staff checked with the person that their meal was cut up in sizes to the person liking. The person used gestures to confirm their satisfaction. The dining tables were height adjustable which ensured people in wheelchairs could sit comfortably when having their meal. There were sufficient staff present to support people with their meals.

The service provided specialist care for adults living with autism and additional learning disabilities or other complex needs. We checked to see that the environment had been designed to promote people's wellbeing and ensure their safety. People's individual needs were met by the adaptation, design and decoration of the service. There was wheelchair access throughout, which meant people could move freely around the shared areas. There was a separate sensory room available for people. The service was well maintained, decorated and furnished in a style appropriate for the young people who used the service. Where required bedrooms were equipped with an overhead tracking hoist. Pathways around the grounds enabled people to move easily between different parts of the service and gardens.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. The provider employed a physiotherapist and physiotherapy assistant to work in the home and physiotherapy support was available each weekday. We observed people being supported to walk using frames or to cycle in the grounds. Records demonstrated that people had been supported to see healthcare professionals including the GP, Chiropodist and Dietician. A GP who was visiting told us, "We visit this service weekly, I personally visit two weekly. We meet with the managers to discuss near misses and significant events. We do ward rounds and have found our instructions are always followed. Nurses here know the individuals well. If we had a concern we would be the first to raise an issue."

Good

Is the service caring?

Our findings

We observed the way staff and people interacted and the care that was provided. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. All interactions we saw were comfortable, friendly, caring and thoughtful. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

Staff had good knowledge of each person and spoke about people in a compassionate, caring way. For example, one person found it hard to find the right words, so staff sat patiently and used their experience of the person to communicate. Staff interacted well with people, touching, reassuring and complimenting people as they passed. We observed that people had been supported to look smart and to dress in co-ordinated clothing. One person wore jewellery that complimented their outfit. People's hair was clean and men were freshly shaved. This demonstrated staff took care in how people wanted to look and how this may affect people's confidence and positive self-image.

The home had no offensive lingering odours and staff ensured people were assisted to the bathrooms discreetly to maintain their continence. Staff supported people who were in pain or anxious in a sensitive and discreet way. This included thinking about whether there may be a physical reason why someone was not behaving in their usual way. People's rooms were homely and comfortable. People were able to decorate their rooms as they wished and display items that were important to them. Laundry was managed by the housekeepers and was well organised with people's clothes well cared for and folded neatly, showing that staff cared about people.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

Most people were not able to tell us about their choices directly due to their communication needs. Care plans contained people's preferences, which gave staff a basis to work with. Staff said they could update care plans as they learnt more about people. They knew what people liked to do and their preferred routines. Staff consistently asked people if they were warm enough and gave out or opened the windows if people were too warm. Communication care plans included how people expressed when they were in pain, for example, the deputy manager told us, "I use the non-verbal pain chart, you look at their body language, pulling up of limbs and facial expressions. With [person] she makes a high pitched cry and limbs contract." A communication care plan stated, 'If I am unhappy I make noises and pull faces. Please check my pad might need changing, my toes might be curled in my shoes, my hip might be painful so I need repositioning, my blood sugar might be low, I might have tummy pain.'

We observed good interaction between people and staff who consistently took care to ask permission

before assisting them. There was a good level of engagement between people and staff. We found staff were knowledgeable on how different people they supported responded to different communication methods. This included picture cards and visual aids. We saw staff using visual aids to help people be able to make decisions. Consequently, this empowered people to express their views. The majority of people were unable to be fully involved as many lacked understanding in day-to-day decisions about their care and treatment. For these people, the home manager asked relatives whether they wished to be involved in decisions about their family, member's care and how often they would like review meetings to take place. Records demonstrated that some relatives were involved in reviewing care plans. This helped to ensure people's views and wishes were known. One staff member told us, "We give opportunities to choose so we show two objects, pictures and talk slowly. Have choices of meals and clothes. We always ask if the person prefers a shower or bath, what time they want to get up and what they want to wear."

We observed that people were treated with dignity and respect and that people had the privacy they needed. We observed when staff were delivering personal care, doors were shut and curtains drawn. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice. A nurse demonstrated understanding of promoting people's dignity when administering a person's insulin. They explained, "We can give in different sites but as she is in a communal area I will give at the top of the arm to preserve her dignity as opposed to lifting her top and injecting into body." We observed that by injecting the insulin at the top of the person's arm their body was not exposed to other people who were in the communal area. Another member of staff told us, "One person uses a brace [the brace is to support the person with their body posture].If this needs adjusting or changing, I take her to her room even though she could go to bathroom. Cover her with a towel, making sure she is not naked on the bed. Some people only have personal care by female staff. Male staff cannot be alone in female resident's rooms. There is advice about this in the staff room. It is in the care plans as well."

Good

Is the service responsive?

Our findings

Overall, records demonstrated and we observed that care was person centred and responsive to people's needs. We have expanded on what requires improvement in these areas in the 'Safe' and 'Effective' domains.

We observed people received personalised care that was responsive to their needs. Care plans provided advice and guidance to staff about people's care and how they wished to be supported. They included information on people's personal care, health care, mobility, social care, communication, religious and cultural preferences, dietary needs and medication. Each care plan contained details of what was important to the person and how best to support them. Information about people's daily routines, likes, dislikes and preferences were contained in their care plans.

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how people's individual needs could be met. The assessments completed prior to an individual moving into the service formed the basis of each person's care plan. The care plan format provided a framework for staff to develop care in a personalised way. The care plans were person centred, had been tailored to people's individual needs and had been reviewed on a regular basis to make sure they were accurate and up to date. Where changes were identified, the information had been disseminated to staff, who responded quickly when people's needs changed, which ensured their individual needs were met. The care plans sampled was written in the first person for example, 'When I am happy I will smile and giggle', 'I like to be asked what I would like to wear and I will indicate by verbalising'. One person's care plan stated the person liked 'warm water, swimming and bubble baths. Sensory lights and music, watching musicals, being outside, going for walks in town, and parks, being with other people.' We observed that the person was in a communal area with other people and they indicated they enjoyed being near to others.

The staff demonstrated a good awareness of how people with complex learning disabilities could present with physical health needs and could affect people's wellbeing. The individualised approach to needs meant that staff provided flexible and responsive care, recognising that people could live a full life involved in the community and interests. For example, a nurse told us she had been working at the home for "about four weeks." Despite being in post for a short time she was knowledgeable about the people she gave their medicines to. For example, with regard to one person the nurse said, "She has [described the person's type of insulin]. She has blood sugars tested four times a day. We have instructions what to do if these are low. She has a PEG, which she has had since a baby. When she is feeling ill she refuses to eat or drink so give via PEG." We observed that the nurse was considerate to the person when checking their blood sugar levels. She explained what she was going to do before doing so. She then checked the guidance regarding safe blood sugar ranges and recommended dosages that was located with the MAR chart and recorded the current reading. Records were in place that confirmed that the person's blood sugar levels were checked four times a day as per the nurse explanation. She also checked the use by date on the insulin before administering. The nurse explained, "The GP came yesterday so I always check dosage recommendations in case they have changed." This demonstrated that staff took time to get to know individual needs and that

care plans were personal to reflect a person's personal history.

Another staff we spoke to was very knowledgeable about the person they were supporting and did not need to refer to records. The staff member told us, "He likes to wander and would drink all the while. He's quite happy walking, a very strong man. He is one to one indoors and two to one outside. He's very helpful if you can communicate with him. For example if you touch, two light taps he will hand you his cup. He is intelligent, if you just say no when he wants to drink he will push you as you just saw earlier. He knows when people are scared of him. He doesn't like wearing shoes but loves a foot rub. He doesn't talk, communicates by pushing you, his facial movements or actions like sitting in a corner. He will get loud or hit he's face if in distress. He loves long showers but doesn't like loud sounds but loves music." For another person a care plan stated they liked a 'small bowl of pureed food (size of two Weetabix), small dessert. If I don't eat give fresubin either in my bottle or down my tube. Drinking – I drink from my spouted bottle. I only drink milk or milkshake. I can only drink from left side of mouth.' We observed staff give food and drink as per these instructions. This demonstrated that care plans reflected how to meet individual needs with their interests and choices included.

We observed that visitors and relatives were welcomed at the service and visited whenever they chose. There were several visitors during the inspection and the front door was always answered promptly by staff that welcomed people and ensured that they signed in the visitors' book before entering the service.

During the inspection people were observed enjoying a variety of activities. These included use of computers in the dedicated computer room, music therapy sessions in the music room and physiotherapy sessions in the Gym. Other people were observed enjoying the extensive grounds that the service was located in with staff assisting them to go for walks. Information about planned activities was on display so that people knew in advance what was available. These included updating scrapbooks, a trip to the park, a music and drama session. One person told us, "I like living here. Like staff, favourite is [staff], helps with stretching." The person smiled when we asked what the food was like and the person responded by saying "Like" and went onto say "like going pub and watching sport with staff." People were supported to access their local community and to maintain links with people who were important to them. The home has its own mini bus that people could use to access the wider community and some people were not present during the inspection as they were using this facility. There was a room allocated for using computers. This was a space for people to contact their relatives through Skype, Facebook and email. The service could accommodate relatives who wished to visit their family.

Staff told us they were aware of the complaints procedure and knew how to respond to complaints. There was a comprehensive complaints policy; this was available to everyone who received a service, relatives and visitors. To help people understand the complaints procedure, it was available in easy read and picture format. The procedure was on display in the service where everyone was able to access it. We were unable to assess how the home manager responded to complaints, as they were unable to provide us with complaint records when requested. Following the inspection we also emailed the provider for this information, which we still did not receive. We have expanded further on this point in the well led domain.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager but at the time of the inspection, this person was no longer managing the service on day to day basis as they were acting in the role of an area manager for the provider. A home manager for the laurels was appointed in January 2017 and had made an application to register with the Commission. The home manager was not available at the time of the inspection. Following the inspection we met with the provider who informed us the home manager had left their position as manager of the laurels. The nominated individual confirmed that the registered manager who had been promoted to area manager had returned to manage the day-to-day activities at the laurels as the registered manager, while the provider sought to recruit for a new manager for the service.

The provider had failed to display the rating from their previous inspection as required by law. This was seen to be displayed at the entrance of the service; however, we noted the ratings were not displayed on the provider's website. We spoke with the area manager about this who told us they would speak to the provider. Following the inspection the rating is now displayed.

The provider had failed to display on the providers website the most recent rating by the Commission of its performance in relation to particular premises or activities. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify the Commission of certain events occurring at a registered service. We found examples where the provider had failed to notify us of certain events including safeguarding concerns, serious injuries and an incident, which had been reported to the police.

The provider had failed to identify and inform the commission of events required by law, such as safeguarding concerns. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found there was a lack of oversight and inadequate monitoring of the quality and safety of the service provided. Systems were in place to assess, monitor and improve the service but these were not being operated effectively as they had not prevented the breaches of regulation we identified from occurring. The area manager demonstrated he had limited oversight. We found that this had an impact on the service, in terms of governance and ensuring quality was sustained. Throughout our visit we found that records were not available, did not exist or staff were unable to access them when requested. This meant that the provider could not provide evidence that they had appropriate governance and oversight procedures in place and could not fully assess the quality and effectiveness of the service. The area manager told us he lacked the knowledge of where records were kept within the service.

For example, the area manager could not locate staffing rotas for the last four weeks, other than the current rota for that day, training matrix to evidence what staff were trained to do and staff training certificates to evidence the training staff had attended. Records of and responses to complaints could not be found, nor the monthly audits that the home manager carried out on the service. The most recent newsletter to people

and their relatives and records of accidents and incidents also could not be located or were incomplete. The inspection team had to wait over two hours for the area manager to locate people's care plans and risk assessments. Reasons for this were not explained to the inspection team. Towards the end of the inspection, one of the inspectors found the records relating to accident and incidents. The inspector found these records on the home manager's bookshelf, which were clearly labelled. The area manager could not explain why these were not given earlier when requested. Following the inspection the area manager emailed the requested documents; however, the area manager was still unable to locate the record of complaints and the provider's response to the complaints. Therefore we were unable to fully assess how the home manager responded to complaints, as they were unable to provide us with complaint records when requested. This also meant that the provider could not assure themselves of how complaints were dealt with in line with their policy as these records could not be located.

We queried each of the audits emailed to us for the months of January to April 2017. The documents were a computerised 'word document' and the properties of the document indicated they had each been modified on the day of being emailed to the Commission. We queried this with the area manager who told us he had had to retype them, as he was unable to locate the originals. This raised a concern regarding the authenticity of the audits we received and the transparency of the area manager. Other examples of concern regarding the area manager authenticity and transparency was the use of agency staff on the day of the inspection. We asked the deputy manager why the original nurse allocated to Cherry Lodge had been swapped with a different nurse. We were told, "The agency nurse who was on shift was swapped with a permanent nurse who was on shift at the Granary [another location] because you lot [CQC] came here." We spoke to the nurse who confirmed she was originally on shift at the Granary that morning 8am to 8pm. This gave a false impression to the inspectors that the staff on duty that day were mostly permanent staff, when actually there would have been more agency staff on shift had we not arrived for the inspection. We also found that on page seven of the provider's 2017 newsletter given to relatives and to people using the service, it stated the name of the manager appointed in January 2017 and it stated that they were the registered manager for the Laurels. This was incorrect and misleading.

The breaches of regulation we identified should have been prevented through the operation of robust systems to monitor quality and compliance. We identified inconsistencies in the quality of care with documentation and care delivery of variable quality dependant on the area of the home. For example we identified some issues with risk management, MCA compliance not being adhered to, care documentation and a lack of assessment of people's needs, as well as observing some good areas of practice in these same areas. Therefore the quality and outcomes for people were inconsistent.

One person who used oxygen had a care plan which stated that the quantity of oxygen must be checked each Sunday. No records of these checks could be found in the file and so a request was made to make this information available to the inspection team. At the end of the day, further request for this information was made and an oxygen checking file was produced. However, the only entry on the chart was for the day of the inspection which was a Wednesday. No other records for this weekly check were supplied; there was no evidence that this weekly check of oxygen supplies had been completed to ensure there would be a sufficient supply to meet the person's need.

We viewed monthly records from January to April 2017, which were structured processes in place for regularly auditing care plans, staff training, staff personal flies, complaints, safeguarding, accidents and incidents, infection control, medication administration and general cleanliness of the home and all aspects of the medication administration records. The area manager's audits did not reflect all of our findings and therefore were not effective in addressing areas for improvement.

Identified and assessed risks to people's wellbeing and safety had not always been effectively mitigated. People who had been identified as at risk of skin breakdown had equipment such as pressure relieving mattresses. Having the mattress set too firm or too soft could result in pressure damage occurring. We found that people who used a pressure relieving mattress did not have a checking system in place, linking weight to pressure relieving mattress settings as described in the guidance for the different manufacturers. There was also no record of the mattresses being routinely checked to ensure they were in good working order or on the correct setting. Records relating to the care and treatment of people were not always complete or accurate. We found a number of issues relating to epilepsy information which lacked detail regarding the risks associated with an activity and the guidance for staff to follow. We found people had not been impacted in regards to the lack of monitoring records and information in peoples epilepsy care plans.

An effective system was not in place to properly analyse incidents that resulted in, or had the potential to result in harm to people, to learn from those incidents and where necessary make changes to their care and reduce risks. Records showed eight incidents from January to March 2017, where people had been injured due to other people's behaviours. These specific incidents had not been fully analysed to identify trends or themes for individuals or for the service as a whole in order to minimise risks and improve outcomes for people.

Whilst accident and incidents were recorded in a separate file, there was no evidence of audits having taken place to account for trends or actions to minimise risk to people who use the service. We asked the area manager who undertook the monthly accident/incident audits. He stated "[home manager]." We asked if he sampled any of the audits completed by the home manager. He stated "No." We showed the area manager the audits in the file. The last audit was dated July 2016. The head of quality and therapies stated that the audits would have been completed. We explained that there was no evidence to support this comment. We explained that a provider or registered manager could delegate tasks and responsibilities but that ultimately the responsibility still remained with them to ensure compliance with the regulations, as per their policy.

The providers 'Incident reporting and duty of candour policy' states:
'The registered home manager has overall responsibility for the provision of adherence to and implementation of this policy. The registered manager must ensure that:
• They grade and review all incidents when reported.
• They set the level of investigation needed and who should do the investigation.
• They ensure that all internal and external reporting are met and be the conduit and lead for that reporting.
• The investigation is completed to timescale.
• They sign off all incident reports and action plans.
• The investigation reports and process are robust, that findings are reported on the risk register and include an action plan to prevent recurrence.
• That all resultant action plans are implemented in a timely fashion to prevent recurrence.
• The incidents are all discussed at the monthly team meeting and that lessons are learnt throughout the service.
• Monthly incident and accident audit reports are compiled and delivered to the area manager.
• They lead and establish key open communication mechanisms with any involved service users, family and/or carers, and be the point of contact in accordance with the duty of candour requirements.'

We found serious concerns with care and support delivery at the home that necessitated several referrals to the local authority safeguarding teams to ensure people's safety. These shortfalls had not been identified by the current management team.

The provider failed to ensure there were appropriate systems implemented to assess, monitor and improve

the quality of the service. The provider failed to maintain securely such other records as are necessary to be kept for the management of the regulated activity. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Satisfaction surveys were undertaken to obtain people's views on the service and the support they received. We saw the relatives views had been requested between May and November 2016, results of which were all positive. However, there were only four responses, three of which were from the same relative. There was no evidence of how many relatives had been contacted. Therefore we were unable to identify how the home manager sought and acted on feedback from relevant persons for continually evaluating and improving services. This is an area requiring improvement.

However, we also saw there were monthly meetings for people who used the service. The minutes of the last meetings were available for all people to see. The minutes were available in an easy to read format for people who used the service to understand, however staff told us that due to how complex minutes can be, they also read them to people. People we spoke with confirmed they did not mind this method.

Staff we spoke with gave us mixed opinions about the current management arrangements, vision, values and culture of the service. One staff member told us, "I would like to say it fosters and encourages growth but sad to say it's not always like that. The care assistants are overworked and undervalued. I think [home manager] is bit hard on them. There should be more staff, he tells them they are moaning. When I raise this he says there are plenty of staff – tell the physio to get out here and do some feeding." However, another staff member told us, "Excellence in care [to provide]. In all aspects of care, for staff and service users. Includes care planning for them that is individualised, providing care that reflects the plans, accurate risk assessments, trained staff and including multi-disciplinary teams. [Home manager in January] is a well-liked manager, good. He really is keen and on the side of service users and staff."

We asked to see records of staff meetings for the months preceding our visit. Staff meetings were held on an ad-hoc basis when called by the home manager. We were told that these occurred when there were updates for staff. Following the inspection the provider informed us staff do have opportunities to discuss concerns and share best practices. For example, through handovers that occur from one shift to the next, which provides staff with the opportunity to share information about any changes in the care needs of people. We were told an information board is displayed in the staff meeting rooms which help keep staff informed of any upcoming information and announcements regarding the service. The provider also told us, a communications book is available where information such as policy updates or legal updates are included where staff need to read and sign to acknowledge that they've read the required information.

We saw various other audits that were being used to improve the quality of care. As a result of these audits there were action plans detailing the improvements being made. This included health and safety audits, infection control, weekly medication audits and weekly temperature checks.

During lunch, the area manager greeted and spoke with several service users. They all responded positively, smiling and gesturing they knew and felt at ease with the area manager. One person using eye gestures asked the area manager who the inspection staff were and if he could talk to us. The area manager supported the person to have a conversation with us. It was evident the area manager knew the person well.

Information leaflets were available in the entrance to the home about local help and advice groups, including advocacy services that people could use. These gave information about the services on offer and how to make contact. There was a suggestion box in the entrance hall of the home where people could raise issues or make suggestions.

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 The provider had failed to identify and inform the commission of events required by law, such as safeguarding concerns. (1) (2) (ii) (iii) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes enabled appropriate investigation of potential safeguarding issues, which placed people at risk of abuse. Failure to gain consent off people and where the person's may have lacked capacity, is not acting in accordance with the Mental Capacity Act 2005. This place's people at risk of have unnecessary control or restriction placed on them that was not necessarily proportionate with the assessed risk. (1) (2) (3) (4) (b) (6) (b) (c) (7) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there were appropriate systems implemented to assess, monitor and improve the quality of the service,

	resulting in the multiple breaches of regulation identified during this inspection. The provider failed to maintain securely such other records as are necessary to be kept for the management of the regulated activity. (1) (2) (a) (c) (d) (ii)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display on the providers website, the most recent rating by the Commission of its performance in relation to particular premises or activities. (1) (2) (c)