Miss Amanda Sutherland

Burlington Care and Support Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Burlington Care and Support Services, known as Burlington House, is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and personal care for up to 13 people with a learning disability. Accommodation is provided over two floors in two separate but adjoining units. At the time of our inspection there were 12 people living at the home: three people in one building and nine people in the other. The home does not provide nursing care. Where needed this is provided by the community nursing team.

The registered provider is also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The provider was supported in the management of the home by a service manager, who was in day to day control.

The home has been established for many years and was working in line with the values that underpin the Registering the Right Support. These values include choice, promotion of independence and inclusion, although the home did not always record how this was being done. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Burlington House was previously inspected in December 2016 and was rated Requires Improvement. At that time we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems to manage risks to the people's safety and welfare and had not notified the Care Quality Commission (CQC) of important events within the home. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to meet the requirements of the regulations. The provider confirmed that personal emergency evacuation plans and risk assessments for each person would be reviewed and rewritten as necessary and that CQC would be notified of all important events in the home that affect people's safety and well-being. Since the last inspection, the home has kept CQC informed of events in the home. However, at this inspection in January 2018, we found improvements were still required to ensure people received safe care, with record keeping, people's dignity was not always respected and systems were not effective in monitoring the quality and safety of the service.

Staff were able to describe people's needs and knew how to keep people safe. However, this level of detail was not recorded in people's risk assessments or support plans. Records relating to the management of risks to people's health, safety and well-being were either insufficiently detailed or staff actions were not being fully documented. For example, one person's risk assessment failed to guide staff about how to support the person at times of anxiety when they were at risk of self-harm. For another person, the actions taken by staff to ensure the person was safe when out of the home were not well documented. We found

that not everyone's dignity as being respected. One person had particular night time support needs and we found their room had an unpleasant odour. Although the provider told us the room was regularly cleaned, the odour remained. In addition, staff had placed plastic 'clinical waste' bags on one area of the person's floor.

The provider did not have effective systems in place to assess, monitor and improve the service. Although they attended the home at least once a week, they did not have a system of documented audits or reviews to demonstrate their oversight of the home. They had not identified the improvements required in the risk assessments and support plans to ensure people received safe and consistent care and support, or that one person's dignity was not being respected. With the exception of manageing fire safety well, regular audits of the safety of the environment, such as hot water temperatures, were not being undertaken. Some improvements to the environment were also required, for example, a number of carpets were wearing thin and fraying.

People told us they were supported to be as independent as possible. However, we found no reference in people's support plans about how their independence was being promoted or their future gaols and aspirations. Support plans were insufficiently detailed to ensure people's abilities, goals and preferences were recognised and supported in a consistent way.

People received their medicines safely and as prescribed. People were supported to use a range of health care services and had regular contact with dentists, opticians and GPs. Where necessary specialist advice had been sought from the learning disability community services.

People told us they felt safe living at the home and they were well supported by staff. One person said, "Yes, it's the best place to live." People knew how to make a complaint and told us they had no concerns. Throughout the inspection we saw staff and people interacting in a friendly and respectful way. People's rights to make decisions and choices about their lives and the support they received were respected. Where necessary, for those people who were unable to make these decisions, capacity assessments had been undertaken and decisions made in their best interests.

Records showed and people told us they were involved in a variety of activities in and out of the home. Each person had a keyworker with whom they planned activities. People's support plans held an activities planner for the week. During the inspection we saw people coming and going from the home and involved cleaning, laundry and meal preparation either independently or with staff support.

Staff were safely recruited and provided with the training they needed to undertake their role. They had regular supervision and appraisal of their work performance and were able to share their views about the home. Sufficient numbers of staff were provided to meet people's needs and to support them in leisure and social activities.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made one recommendation for improvement.

You can see what action we told the provider to take at the back of the full version of the 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.

People were not fully protected from risks to their health and safety. Risk assessments and management plans were insufficiently detailed to ensure staff had appropriate information to keep people safe.

Staff were recruited safely and were available in sufficient numbers to meet people support needs.

People were protected from the risk of abuse as staff had received training in safeguarding adults and were aware of their responsibilities.

Medicines were managed safely and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People's rights to make decisions about their care and support were respected.

Staff received the training and support they required for their role.

People were supported to use healthcare services.

People's needs and preferences in relation to eating and drinking were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Not everyone's dignity was being respected.

Staff had developed kind and caring relationships with people.

People's independence was supported, although records did not

demonstrate this.

Is the service responsive?

Requires Improvement

The service was not always responsive

People were at risk of not having their needs and preferences recognised and supported as support plans did not describe these well.

People were involved in a variety of activities both in and out of the home.

People knew how to make a complaint but had no concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not established an effective system to assess, monitor and improve the quality and safety of the service.

People and staff found the management team approachable and supportive.

The provider sought feedback from people, relatives and health and social care professionals.

Burlington Care and Support Services

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 was 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 the 4 and 9 January 2018: the first day of our inspection was unannounced. One adult social care inspector carried out this inspection.

Prior to the inspection, we reviewed the information held about the home. This included previous inspection reports and notifications we had received. A notification is information about important events, which the home is required to tell us about by law.

During the inspection, we met most people who living in the home and spoke with nine people individually. We also spoke with the provider, the service manager who managed the home on a day to day basis for the provider, five members of staff and one relative. We contacted South Devon and Torbay NHS Foundation Trust's quality assurance and improvement team (QAIT) and the specialist intensive assessment and intervention team (IATT) who provide guidance and support to learning disability services. We did not receive a reply from the IATT team. We reviewed the support plans for three people and looked at how the home supported people with their medicines. We reviewed the recruitment records for three staff as well as the staff training records and those related to the running of the home.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in December 2016, we identified that people were not always protected from the risk of harm. We found risks such as those associated with people's behaviours had not always been identified. In some cases, guidance was not provided to staff to mitigate these risks. In addition, we found the personal emergency evacuation plans (PEEP) which were in place
to ensure staff know how to assist each person to leave the building safely in the event of an emergency had not been completed for all people currently living at the home.

At this inspection in January 2018, we found some improvements had been made. Each person had a PEEP but some of the other risk assessments and guidance for staff about how to keep people safe were either insufficiently detailed or the actions taken by staff to ensure people's safety were not well documented. We looked at the support plans and risk assessments for three people living in the home. Each person's file held support plans for an individual care and support topic, such as personal care. These were used to guide staff about people's support needs and whether there were any risks to people's safety and wellbeing. One person had needs in relation to anxiety which might lead them to self-harm. We found their support plan and risk assessment were insufficiently detailed to enable staff to support this person in a safe and consistent way. For example, the staff were guided to, "Help me understand my feelings and be able to express myself. This will help me control my anxiety." There was no further guidance for staff about the circumstances that might increase this person's anxiety, how to respond to the person when they indicated they were anxious, or how to support the person should they self-harm.

Another person had an agreement in place with the home to let staff know when they were going out and to confirm when they would be returning. If the person wished to stay out overnight they were to let the home know by 10pm and tell the staff where they were. The agreement instructed staff to contact the person if they had not returned home ½ hour after they were expected to and if they had not heard from them by 10pm. If staff were unable to contact the person, they were instructed to contact the police to report the person missing. We found that on a number of occasions staff were not following this protocol. They had either had not made contact with the person or called the police, or had failed to record the person's whereabouts. This meant the home could not be sure this person was safe. For example, on 23 November 2017, the person's daily care notes stated, "[Name] has been out all day and has not arrived home by 10:30." There were no other entries about staff attempting to contact the person to ascertain their whereabouts and to ensure they were safe. We could not determine what happened the following day as no care notes were recorded for 24 November 2017.

The lack of detail in people's risk assessments and support plan meant staff were reliant on what they knew or had been told about people's support needs, rather than being provided with detailed written information that was kept up to date with people's changing support needs.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the provider, service manager and staff about the lack of detail in the risk assessments and the inconsistencies in following the agreed protocol to ensure people were safe. They were able to describe how staff provided support and reassurance to the person known to be at risk of self-harm. They provided examples of how the person demonstrated they were anxious, what to say to the person to let them know staff were listening and how to offer support, by sitting with them in a quiet environment. This level of detail had not been included in the person's support plan or risk assessment. They also acknowledged that staff had not documented the whereabouts of the person who stayed out overnight. They gave assurances that the names and contact details of the person's friends were known and the person had a usual routine of where they stayed. We spoke with both these people and they told us they were well supported and felt safe living in the home.

People were protected from the risk of scalds from hot water as the temperature of the hot water to the sinks in their rooms and in the bathrooms were controlled. We tested the water in a number of sinks and found them to be within a safe temperature range. However, the provider was not undertaking any regular checks to ensure the temperature stayed within a safe level, under 43 degrees centigrade. The provider gave assurances that all hot water outlets in people's bedrooms and the communal bathrooms would be tested and kept under review. Following the inspection, the home confirmed these checks had commenced. In 2016, the provider had commissioned a specialist company to assess the home for the risk of Legionnaires Disease. The home's water system was found to be safe. However, the home had not undertaken any routine checks of the water system as recommended by the Health and Safety Executive for ongoing management to reduce the risk of Legionnaires Disease.

We recommend the home seeks guidance from a reputable source about how to manage the risk of Legionnaires Disease in the home.

We saw that other risks to people's safety and welfare were being managed well. For example, one person was at risk of choking. We saw staff supporting this person with food and drinks that had been prepared to a soft and thickened consistency to reduce their risk of choking. Another person had reduced mobility and we saw staff supporting them with transferring to and from their chair and when walking around the home safely.

All the people we spoke with told us they felt safe living at the home. One person said, "Yes, I like it here" when asked if they felt safe. Another person said, "Yes, it's the best place to live." People were protected from the risk of abuse as staff had received training in safeguarding adults and whistleblowing. Staff had good understanding of how to keep people safe and how and who they would report concerns to. People had been provided with information about how they could seek advice or raise a concern. People and staff told us they felt comfortable and confident in raising
concerns with the service manager or provider.

At our previous inspection in December 2017, we found that people were supported to receive their medicines safely and as prescribed. At this inspection we sound this safe practice continued. Only staff who had received training in the safe administration of medicines supported people with their medicines. The service manager undertook regular monthly checks of all medicines received into the home and disposed of, as well as a review of the medicine administration records (MARs) to ensure they had been fully completed. We checked the MARs and found no gaps in recordings. Where people had been prescribed medicines to take as and when needed, clear protocols for their use were included with people's MARs and records showed when and why these medicines had been given.

Staff were recruited safely. We looked at the recruitment records for thee of the most recently recruited staff.

All the files contained the necessary pre-employment checks, including references from previous employers, proof of identity and disclosure and barring service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults in a care setting. This helps employers make safer recruiting decisions. At the time of our inspection there were four care staff on duty in addition to the service manager. The duty rotas showed that between two and four staff were on duty during the day dependent upon people's planned activities. The service manager said staffing levels were flexible to support people's individual needs. Overnight there were two sleeping-in members of staff. People told us that if they needed assistance in the night they would knock on the staff members door or, for those living in the smaller adjacent building, call for assistance using a bell that sounded in the staff member's room.

Accidents and incidents were appropriately recorded and analysed to identify any trends. The service manager confirmed that should an accident happen, they reviewed the circumstances and whether any action was necessary to reduce the likelihood of a reoccurrence.

Fire safety was managed effectively within the home. Regular checks and servicing of the fire alarm system, emergency lighting and fire extinguishers were undertaken. Staff and people living in the home were regularly involved in fire safety drills and knew what action to take should they discover a fire or should the fire alarm sound. People were protected from the risk of burns from radiators as these were covered. Infection control practices were safe. The home was clean and we observed staff using gloves and aprons as appropriate.

Good

Is the service effective?

Our findings

At our previous inspection of Burlington House in December 2016, people spoke positively about the care and support they received. At this inspection, we found people remained satisfied: people told us they were happy living at the home.

Many of the staff had worked at the home for several years and knew people well. Training records showed staff received training in health and safety topics as well as those relating to people's support needs. The home used an on-line training resource and face to face training for those topics with a practical element, such as first aid. Other topics included how to support people who were living with epilepsy, people whose behaviour might place themselves and others at risk of harm, the Mental Capacity Act 2005 and person-centred care. Staff received regular supervision and appraisal of their work performance. Staff were provided with an opportunity to discuss their personal development and to identify any training needs.

People were supported to use a range of health care services and had regular contact with dentists, opticians and GPs. People's support plans contained details of their appointments and any action required from staff to support people with their healthcare. People were invited and supported to undertake healthcare screening such as well-woman and well-man checks. Each person's support plan contained a health passport, which contained information of the person's care and support needs. These passports would be used to ensure important information about each person was available to healthcare staff if the person required a hospital admission.

Where necessary specialist advice had been sought from the learning disability intensive assessment and treatment team (IATT). For example, staff had anticipated one person would require additional support when facing a bereavement, and had sought advice and guidance prior to and following the death of a family member.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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. Staff had a good understanding of the principles of the MCA and DoLS and were knowledgeable about how to ensure the rights of people were protected. The majority of people living at the home had capacity to make their own decisions. Records showed that for those people who lacked capacity to make decisions about their care and support, appropriate assessments had been undertaken and best interest decisions made on their behalf. Staff understood the necessity to seek people's consent before offering support.

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 are called the Deprivation of Liberty Safeguards. The home had applied for authorisation to place a restriction on one person's liberty as they would be unsafe to leave the home without staff support. The home was in the

process for applying for authorisation for another three people who, due to their changing needs, now required a higher level of staff supervision.

People told us they liked the food at the home. They said they helped with shopping and were involved in meal preparation if they wished. People had access to a kitchen in each of the two buildings and we saw people making themselves drinks and snacks throughout the inspection. People said they were asked about what meals that wanted on the weekly menus and we saw staff asking each person what they would like for lunch. People could choose what they wished and did not have to have the same as each other.

At the previous inspection in December 2017, some areas of the home required refurbishment. At this inspection we found improvements were still required. The service manager told us the plans to upgrade a ground floor bathroom had been delayed due to complications with the drainage. However, we found the frayed and thinning carpets, although not yet a trip hazard, had not yet need replaced and a bed base and mattress identified for future use were being stored in a hallway and a lounge room. The provider's refurbishment plan identified the replacement of carpets and general decoration of the home. The carpets were scheduled to be replaced by March 2018. By the second day of the inspection, the bed base and mattress were being moved into a person's bedroom.

Requires Improvement

Is the service caring?

Our findings

People living at Burlington House told us they were very happy living there. One person said, "I really like it here. I've got everything I need" and another said, "It's good". They described the staff as nice, friendly and kind.

However, we found that staff had not always respected people's dignity. The provider told us about one person with particular night time support needs. This person showed us their bedroom and we found it had an unpleasant odour. Although the service manager and provider told us the room and carpet were regularly cleaned, the odour remained. The provider said they were looking at providing an alternative floor covering to part of the room, but had not yet done this. This meant the person remained in a room with an unpleasant odour. In addition, staff had placed plastic 'clinical waste' bags on one area of the person's floor as a way of dealing with a hygiene issue. This meant staff had not given proper consideration to protect this person's dignity.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection we saw staff and people interacting in a friendly and respectful way. People were seen laughing and joking with staff. A relative visiting the home at the time of the inspection spoke positively about the staff and the way in which their relative was supported. They said the staff were friendly and welcoming.

Staff were attentive to people's needs and recognised when our presence was causing some concern to one person. We saw staff telling them about our visit and sitting with them until they were more relaxed. Staff recognised that Burlington House was people's home and they wanted people to feel part of a "family". One member of staff said, "We're one big happy family."

People told us they were involved making decisions about their care and were supported to be as independent as possible. They said they knew about their support plans but not everyone had or wanted a copy of their plan. Each person was provided with a member of staff who acted as their keyworker, supporting them with their decisions and working together to enhance their skills and abilities. One person said they were learning how to look after themselves to be able to move to more independent living. The provider told us the home had been successful in supporting a number of people to move to their own homes in the community. They remained in contact with them and provided a few hours of support to people each week. The provider said their aim was to support people to move on if that was what they wished. Some people required support with budgeting and managing their finances, while other people required support with how to maintain their own environment, prepare and cook meals and to undertake domestic tasks. People were supported to maintain important relationships and to stay in touch with their friends and relatives. People said their relatives and friends were always welcome at the home.

Confidentiality was maintained throughout the home and information held about people's support needs

and medical histories were kept secure. Where necessary, information was provided in accessible formats, such as easy read with simple wording and symbols, to help people understand their support plans.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in December 2017, we found people's support plans were informative, and designed to help ensure people received personalised care that met their needs and wishes. At this inspection in January 2018, the support plan format had been changed and we found the support plans lacked sufficient detail to guide staff in supporting people in a way that met their needs and preferences in a consistent way.

None of the three support plans we looked at contained sufficient information about people's abilities, and how staff should provide support. For example, one person's plan in relation to their personal care needs stated, "I need you to prompt me lots to complete my personal care as I don't always prioritise this" and "you also need to support me with my room cleaning and laundry." There was no other guidance for staff about how to support this person. A recent support plan review stated, "Staff finding it difficult to promote [name] personal hygiene" and said the person responded to incentives. There was no information to guide staff about what action to take to support this person with their personal care or what the incentives were that the person responded to. The person's daily care notes made no reference to how they were managing their personal care, whether any prompts had been required from staff and whether the person was maintaining the cleanliness of their room and undertaking their laundry. Staff were not provided with any information about how to support this person in a consistent way which recognised the person's responsibilities toward their own health and welfare and to their environment.

Another person had been referred by the home to a special support team for people with autism. The team made a number of recommendations to support the person with their communication. These included, "Be clear about what is expected of him and what is happening" and "There is clear evidence to suggest that [name] may find it difficult to adjust to changes and so consistency may be important to him as well as preparing him in advance when plans are due to change." This important information about the considerations necessary to support this person was not included in this person's support plan. The person's support plan stated, "Can communicate verbally" and "Due to [name] mental health condition he can at times misunderstand other people's actions or expressions" and "staff to listen to [name], reassure and if remains anxious prn", (prn medicine is prescribed to be given 'as and when' needed). There was no guidance for staff about how they should offer reassurance or any interventions known to be effective in reducing this person's anxiety before giving the person medicine. The advice provided by the special team identified consistency was important to this person. Without clearly written guidance, staff were not in a position to provide support in a consistent way that recognised their specific needs. While staff who had worked at the home for some time were familiar with this person's needs, staff new to the home would be reliant upon the information they received verbally from staff.

The majority of people living at Burlington House were young adults and they told us they were being supported to be as independent as possible. However, only one of the three support plans we looked at identified what the person wished for their future. The support plans for the two other people contained no information about their future goals and aspirations. None of the three plans made reference to how people were being supported to learn and improve their independent living skills. There was no information about

whether people were making progress with their development or what they had achieved and what choices they had made about their future learning.

Failure to provide a care and support plan designed to achieve people's preferences, including their goals and ensure their individual and specific needs are met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were involved in a variety of social activities as well as being involved in the day to day running of the home. The majority of people went out of the home independently. On the first day of the inspection, a number of people were out and one person was going out with their family: they told us, "I'm looking forward to going to the shops." Another person told us how much they enjoyed swimming and went to the local swimming pool. They said they had swum 25 lengths the day before the inspection. One person told us proudly of the job they had at the local church hall. They said they helped with the weekly coffee morning. Each person had a keyworker with whom they planned activities. People's support plans held an activities planner for the week. For those people who required staff support to go out of the home, staffing levels were flexible to allow this to happen. During the inspection we saw people coming and going from the home and involved with cleaning, laundry and meal preparation either independently or with staff support.

People told us how they would make a complaint if they were unhappy about anything. They said they would speak to the staff or the service manager. People said staff encouraged them to share their views. No one we spoke had any concerns about the care and support they received. One person said, "No, I'm a happy here" when asked if there was anything they were unhappy with at the home. The relative we spoke with had no concerns. They said the staff were approachable and they would feel comfortable talking to them if they had a concern. Staff told us the management team were approachable and they felt able to express their views and raise concerns with confidence. The home had received no complaints within the last 12 months.

All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. CQC have committed to look at the Accessible Information Standard at inspections of all services from 01 November 2017. The provider and service manager had ensured information, such as the complaints procedure, some people's support plans and information about the importance of medicines had been prepared in an easier to read format with clear wording and pictures and symbols to support people's understanding.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in December 2016, we identified the provider did not have effective systems in place to manage risks to people's health, safety and well-being and to ensure we were informed of important events in the home. Following that inspection, the provider sent us an action plan detailing what they were going to do to improve. This included keeping us up to date with events in the home and ensuring people's risk assessments were reviewed and rewritten if necessary. At this inspection we found some improvements had been made. However, further improvements were required to ensure the provider assessed and monitored the quality and safety of service. This was needed to ensure people received safe care and support, to protect people's dignity at all times and provide staff with clear guidance and information about people's specific care and support needs.

Following the previous inspection, the home had been supported by South Devon and Torbay NHS Foundation Trust's quality assurance and improvement team (QAIT). This team provide support in assessing the quality and safety of services as well as providing guidance with risk assessments and support plans. We found the service had not yet implemented the recommendations made by QAIT.

We reviewed what systems the provider used to monitor the quality of the care and support provided and the safety of the environment. The service manager had recently undertaken a medicine audit to ensure practices within the home were safe and also an assessment of the precautions necessary when the home experienced an outbreak of diarrhoea and vomiting. Both these assessments were thorough and indicated the home's practices were safe. However, no other reviews or audits had been undertaken, such as reviewing the quality of the support plans and ensuring regular reviews were being undertaken; routine infection control practices; the cleanliness of the environment and monitoring hot water temperatures. There was no record of how the provider ensured people's risk assessments and support plans were up to date and accurate and that the environment was safe. The provider told us the service manager, supported by the deputy manager, was in day to day control of the home and of monitoring the quality and dafty of the services provided. The provider visited the home at least once a week and spoke to people and staff. They said they walked around the environment to make sure it was clean and tidy. However, they did not record their visits or what action they took to demonstrate their oversight of the home. The provider had not identified people's risk assessments and support plans were insufficiently detailed to guide staff in the safe and consistent support necessary to their people's needs.

The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service and had failed to maintain accurate, complete and contemporaneous records for each person living in the home. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service manager told us they were determined to improve the quality of the documentation within the home. They recognised that as a well-established home with a stable staff team who knew people well, the information held in the support files did not reflect their actual practice. They were due to meet with QAIT again and they would be seeking further guidance with developing their quality assurance systems. QAIT

told us the home was working co-operatively with them and were keen to improve.

In June 2017 the provider had sent questionnaires to relatives and health and social care professionals involved in people's support, such as social workers, to seek their views about the home. The results of these questionnaires were very positive. Comments included, "excellent working relationship" and "flexible person-centred approach". Staff were described as "lovely people" who were friendly, caring and helpful. The service manager told us they also invited people to share their views about the home using these questionnaires. However, they were unable to provide us with the results. Throughout the inspection, all the people we spoke with told us they were very happy living at the home and they were well supported by staff.

Records showed staff were invited to attend regular meetings to discuss events in the home, review people's support and identify any improvements required. The meetings also discussed staff's responsibility to alert the service manager and provider to any worries or concerns they had over people's welfare. Staff told us they felt well supported by the service manager and the provider. They described the home as a good place to work. One member of staff said, "It's brilliant" and another said, "It's the best place to work."

Since the previous inspection, the provider has kept us informed of important events within the home. The service manager said the home kept up to date best practice by subscribing to CQC's updates and by accessing training and professional websites.

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 The provider had failed to ensure each person had a care and support plan designed to achieve their preferences, including their goals and to ensure their needs are met. 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff had not always respected people's dignity. 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people received safe care and treatment. 12(1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service.

The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home.

17(1)(2)(a)(c)