

Bright Care Limited

Brightcare

Inspection report

20 Taylors Lane

St Mary's Bay

Romney Marsh

Kent

TN29 0EU

Tel: 01797366866

Date of inspection visit:

07 July 2016

08 July 2016

Date of publication:

15 September 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We undertook an unannounced inspection of this service on 7 and 8 July 2016. The previous inspection took place on 3 December 2013 and found there were no breaches in the legal requirements at that time.

The service is registered to provide accommodation and personal care for up to five people who have learning disabilities, including mental health and some complex and challenging physical needs.

Accommodation is provided in a detached house in a quiet residential area of St. Mary's Bay. Accommodation is arranged over the ground floor and each person had their own bedroom. The home benefits from an enclosed back garden with wheelchair ramps and seating areas.

This service had a registered manager in post. A registered manager is a person who is 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.

At the time of inspection four people lived at the service. We met and spoke with each person. People told us that they liked living in the home, they were happy, they liked the staff and the staff were kind. They thought the home provided a safe, relaxed and comfortable living environment.

Our inspection found that whilst the service offered people a homely environment and their care needs were being supported; there were shortfalls in some areas that required improvement.

Arrangements did not ensure the correct storage of medicines and records for disposal of medicines were incomplete.

Items requiring replacement, maintenance or repair, although identified had not been completed and time scales were not set to ensure this happened.

People's goals and wishes were not progressed to encourage development of learning and exploring new activities and challenges.

Authorisations and decisions, made under the Mental Capacity Act 2005 to deprive people of their liberty, were not notified to the Care Quality Commission when they needed to be.

The service had access to the local authority safeguarding protocols, and incidents that warranted referrals to the authority were made.

Quality assurance checks were not wholly effective in identifying some shortfalls or ensuring known concerns were progressed to their conclusion.

Checks ensured sufficient medicines were ordered, the right amount was given and that people received the right medicines when they were supposed to.

All staff had an understanding of the Mental Capacity Act 2005, and Deprivation of Liberty safeguards, they understood in what circumstances a person may need to be referred and when there was a need for best interest meetings to take place.

People told us that they felt safe in the service and when they were out with staff.

People had personalised records detailing their care and support, including well developed support plans for their health needs.

People were supported to access routine and specialist health care appointments. People told us staff showed concern when they were unwell and took appropriate action.

People, relatives and visiting professionals had opportunities to provide feedback about the service both informally and formally. Feedback received had been positive.

People felt the service was well-led. The registered manager worked alongside staff; they took action to address any concerns or issues straightaway to help ensure the service ran smoothly.

The provider had a set of values, which included treating everyone as an individual, working together as an inclusive team and respecting each other. Staff were aware of these and they were followed through into practice.

We found a number of breaches the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 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 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.

Some practices concerning the storage and disposal of medicines did not always promote safe practice.

Maintenance issues were identified, however, appropriate action to address them was not always given sufficient priority or a date for completion.

There were sufficient staff on duty to meet the needs of people, support their activities and health care appointments.

Risks associated with people's care and support had been assessed and people felt safe.

Is the service effective?

Good 

The service was effective.

The service was meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

People consented to their care and treatment and staff were trained to support people's specific needs.

Communication was effective, staff understood people's needs. People told us they had choices about what they ate and how their meals were planned.

People were supported to maintain good health and had access to medical and social services as needed.

Is the service caring?

Good 

The service was caring.

Staff delivered support with consideration and kindness.

People were treated with respect and their dignity was protected.

Staff encouraged people to be independent when they were able.

Is the service responsive?

The service was not always responsive.

Reviews of people's goals and ambitions were not clearly recorded or actively pursued.

A complaints procedure was not displayed and could not be located within the service.

The service involved people and their families or advocates in planning and reviewing care.

Care plans were individual and person centred.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Statutory notifications required by CQC were not always submitted.

Quality assurance processes were not always effective to ensure required actions were identified and progressed.

Staff felt supported; there was an open culture in the service which encouraged staff and people to share their views.

Staff had a good understanding of the values and goals of the service.

Requires Improvement ●

Brightcare

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.

We undertook an unannounced inspection of this service on 7 and 8 July 2016. The inspection was undertaken by one inspector, this was because the service was small and it was considered that additional inspection staff could be intrusive to people's daily routine.

We reviewed a range of records. This included three care plans and associated risk information and environmental risk information. We looked at recruitment information for three staff, their training and supervision records in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints information and records of some equipment, servicing information and maintenance records. We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the registered manager and provider. We spoke with each person, three staff and the registered manager. Not everyone was able to verbally share with us their experiences of life at the home. This was because of their complex needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed responses to the daily events going on around them, their interaction with each other and with staff.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and healthcare professionals. We reviewed notifications of incidents and other documentation that the provider had sent us since our last inspection. A notification is information about important events which the home is required to tell us about by law.

Is the service safe?

Our findings

People told us they were happy and felt safe living at the home. Comments included, "I like it here, it's happy" and "It's the best home". People were comfortable within their home environment and appeared reassured by the staff who supported them. Although people told us they felt safe, we found some concerns which meant the service was not always safe.

Medicine management was not safe. We assessed the procedures for ordering, receipt, storage, administration, recording and disposal of medicines. A central medication area provided temporary storage for newly received medicines, prior to distribution to individual secure medicine cabinets; it also acted as a storage area for any medicines due to be returned to the pharmacy. Non refrigerated medicines need to be stored at temperatures not exceeding 25°C, this is because storage above this temperature risks medicines becoming desensitised, not working as intended or potentially ineffective. Temperatures were not monitored in the temporary storage area and therefore the service were not aware if the maximum temperature was exceeded.

Procedures for the return of medicine no longer required were not wholly effective; our checks showed the return of some medicines were unaccounted for within the service's records. This was however resolved during the inspection by the receiving pharmacy. Processes in place did not ensure complete records were maintained and medication audits were not sufficiently robust to identify this shortfall.

Medicines were not stored appropriately or recorded as disposed of safely. The provider had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise, medicines were administered safely; staff had received training in medicines administration and were knowledgeable about the level of help people needed help with medicines. Any known allergies were recorded on people's medicines files and within their care plans. This reduced the risk of people being given medicines which had previously caused adverse reactions and which could be unsafe for them.

The registered manager carried out health and safety reviews across the service and quickly identified any potential hazards. The regional Head of Compliance visited regularly to undertake service reviews which included environmental checks. Although potential hazards were identified, appropriate action to address them was not always given sufficient priority or a date for completion. For example, when activated, the interaction of both fire doors closing in the kitchen at the same time meant that one or both of the doors did not always fully close automatically as intended. Although the maintenance team had investigated this problem, it had not been resolved. Some kitchen cabinet doors were water damaged, exposing the inner wooden carcass. This meant areas were porous and could not be effectively cleaned. Again, although the kitchen had been authorised for replacement, no time line or completion date were established. The bath chair had been checked by a service engineer, it was not serviceable and a replacement was needed; arrangements were not in place for this to be carried out. Storage within the home was an issue, with some wheelchairs stored in the bathroom and a shed in the garden. The shed door was ill fitting, the window was

missing and other holes in the shed would allow rain, birds and rodents to enter. The shed was not suitable for its use, this had been identified by the registered manager but not resolved by the provider. Staff had identified difficulties using a lifting hoist in one of the bedrooms which was deeply carpeted, this made it difficult to use the hoist smoothly and comfortably for the person receiving support. The registered manager was aware of this concern, discussions had taken place with the person's family but no plan or completion date had been made for the service to install a different floor covering.

Maintenance arrangements had not ensured identified concerns were suitably addressed. The provider had not ensured the premises and equipment used by the service was properly maintained. This was a breach of Regulation 15 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with people's care and support had been assessed and procedures were in place to keep people safe. Staff knew the different risks associated with each person and how to minimise any occurrence. Risk assessments were in place to help keep people safe in the service and when outside or attending activities. They clearly set out the type and level of risk as well as measures taken to reduce risk. These enabled people to be as independent as possible. For example, they included safety in public places, crossing the road and using transport. This helped to ensure that people were encouraged to live their lives whilst supported safely and consistently. Risk assessments were reviewed when needed and linked to accident and incident reporting processes. Accidents and incidents were managed in a way which protected people from the likelihood of recurrences. Staff had completed detailed incident reports and the registered manager had recorded their actions in every case. This helped to ensure the service learned from incidents and put processes in place to reduce the risk of them happening again.

Staff knew how to recognise different forms of abuse and were confident in how to report it. There was a policy and procedure that informed them about what to do. The service also held a copy of the locally agreed safeguarding protocols. Staff told us they knew people very well and could pick up on any changes in their moods or behaviour; which might be an indication that the person was troubled. We observed people seemed comfortable and relaxed with staff and each other and, where possible, people told us they felt safe. Leaflets available to staff encouraged them to whistle blow if they felt something was wrong at the service; staff told us they had confidence in this system but had not needed to use it.

There were enough staff in place to meet people's needs; and requests for assistance were anticipated and met promptly during the inspection. There were three support staff and the registered manager on duty during our inspection. Support at night was provided by one wake night and one sleep night staff. Rotas showed staffing levels were consistent in the month prior to the inspection and the registered manager explained staffing was based on people's dependency levels. People at the service ranged from largely independent to full dependency. We observed staff had time to chat with people and interact with them on a one to one level. People and staff felt there were enough staff on duty. Any shortfall in staff was addressed either through existing staff working extra hours or by agency staff. The service used the same agency and, if possible, the same member of staff. Agency staff received an induction which helped to ensure people were supported consistently and safely.

We read three staff recruitment files to make sure proper pre-employment enquiries had been made. All appropriate documentation had been completed and references, identity and Disclosure Barring Checks (DBS) checks had been recorded. DBS checks establish if any cautions or convictions mean that an applicant is not suitable to work at a service. Interview notes had been kept and these showed the service had made efforts to take on the best staff for the job and some people were asked for feedback about what they thought of the candidates. There was a robust recruitment process in place; which helped to protect people using the service.

Fire alarms had been tested and documented weekly; and fire exits were clearly signposted. Staff had received fire safety training and were able to correctly describe evacuation routes. People had individual emergency evacuation plans in place describing the support they would need in case of fire. Full building evacuations had been carried out to identify any issues. Extinguishers and emergency lighting had also been regularly tested. The service had a formal strategy to ensure people received safe and continuous care in case of emergencies at another local care home.

Records showed the provider ensured proper checks were carried out of the electrical installation in the service; the gas safety certificate was current and portable electrical appliances checked. Appropriate testing and monitoring of water temperatures ensured people were safe from risks of scalding; other water management checks prevented risks posed by Legionella, a water borne bacteria. Arrangements were in place for the service and maintenance of the fire alarm and fire fighting equipment. The fire alarm had recently been upgraded with the addition of new fire call points and a new control panel.

Is the service effective?

Our findings

People spoke fondly and were positive about their home and the staff who supported them. They told us they received the right amount of support and felt staff supported them well. Commenting about the staff, one person told us, "All staff are good". Another person said, "They make me feel settled and understand me".

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Individual capacity assessments had been made where there was a reason to question people's ability to make certain decisions for themselves. Where it had been deemed that they lacked capacity to do so, best interest meetings had been evidenced.

Formal consent to care and treatment had been signed by people who were able to agree to it and we observed that staff routinely gained verbal consent when they were supporting people by saying, for example; "Can I help you with that or are you ok to do it yourself?". Where people were not able to communicate their wishes verbally, staff used objects of reference, such as choices of drinks or offered people things they liked to hold or have around them. Staff looked for and recognised facial expressions, mannerisms and vocal noises people made which indicated choice or preference. The service acted in accordance with people's wishes.

Staff had received training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS form part of the MCA and aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used. Restrictions could include, for example, bed rails, lap belts, restrictions about leaving the service and constant supervision inside and outside of the service.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. Applications had been made to the local authority for each person at the service. Decisions about two of the applications resulted in the granting of authorisation to impose restrictions. The applications for the remaining people were pending decision by the Supervisory Body. All granted authorisations were current and the conditions set out in them were met.

Some people were able to give consent about aspects of their care and support. Some of these decisions were made by people with support of their family or independent advocates. Advocacy seeks to ensure that people, particularly those who are most vulnerable, are able to have their voice heard on issues that are important to them. Where people were unable to consent to some larger or more important decisions, best interest meetings took place. These ensured professionals, staff and where possible family members who knew people well were involved in decision making. This helped to ensure that the right decisions were made for the right reasons.

People had individual communication plans. These helped to ensure effective understanding between people and staff. Where needed, this included information about facial expressions, body language and gestures as well as other indicators such as people's general demeanour and what any changes may indicate. For example, how people may appear and react if they experienced pain, anxiety or were becoming frustrated. Staff were aware of people's communication needs and used them effectively.

People's healthcare needs had been addressed by the service. They had regular appointments with opticians, dentists and chiropodists and each person had an individual Healthcare Action Plan. This listed people's medical histories, their medication and recorded the outcomes of annual health checks with GPs. People's health needs had been assessed and the service worked with other professionals to promote people's well-being. These included epilepsy specialists, occupational and speech and language therapists as well as the local Mental Health Team. Where specialised equipment was needed such as a pressure relief mattress, cushions and orthopaedic chairs, these had been provided and were being used. Adaptations such as hand rails were provided to help people with their mobility around the service.

The service did not subscribe to the Care Certificate, which is an identified set of standards that social care workers should keep to in their daily working life. The Care Certificate is not a mandatory requirement; however, the expectation is that appropriate staff who are new to services will achieve the competences required by the Care Certificate as part of their induction. The induction programme in place, in combination with mandatory and vocational training provided, broadly addressed each standard set out in the Care Certificate and met the needs of staff employed and people supported.

Staff received regular training in areas essential to the effective running of the service such as fire safety, first aid, infection control and food hygiene. A training planner identified when training was due and when it should be refreshed. Additional training had been delivered which helped staff support people, including epilepsy, dementia and learning disabilities awareness. All staff had received training in conflict management and disengagement. Staff told us the training was good quality and they felt confident to do their job properly. The service had identified the benefit of providing training to support people with mental health difficulties, following the recent admission of a person. However, although identified, a date had not been arranged for this to take place.

Supervision and appraisal of staff took place when planned. Supervisions are formal meetings between staff and the registered manager, but also included group supervision of some common practices as well as written and observational assessments. Supervisions covered achievements, training and individual actions or targets for staff. They gave staff the opportunity to raise any concerns about working practices and focussed on ideas to progress individual development of staff. Staff told us supervisions were useful for their personal development as well as ensuring they were up to date with current working practices. Supervision processes linked to staff performance and attendance and, where needed, led to disciplinary action.

People had enough to eat and drink. The meals served during our inspection looked appetising. People finished their meals and where possible people told us they had enjoyed them. Staff were aware of people's food preferences and any specific dietary requirements for fortified food and drinks. Pictorial reference cards and a pictorial menu helped people choose what they wanted to eat. Where specialist advice was received about the consistency of some people's food and drink to protect them from the risk of choking or accidentally breathing in food; staff ensured it was prepared as needed. Some people helped to prepare food and one person showed us a cake they had made. One person told us they enjoyed a glass of coke and a bounty bar and showed us where they were kept in the kitchen.

Staff and the registered manager kept in touch with people's families; they recognised it was important and

told us relatives enjoyed hearing about people's achievements and day-to-day activities.

Is the service caring?

Our findings

People told us the staff supporting them were kind and felt that they cared about them; they found this comforting and reassuring. One person told us, "I am happy this is my home" another person said, "Staff have been good to me and helped me settle in". People were treated respectfully and with dignity.

There was a pleasant atmosphere in the service, some people laughed and joked with staff enjoying shared humour. People were relaxed and appeared comfortable in each other's company; and their different personalities were clear to see. Staff demonstrated they knew people as individuals and engaged them in different ways according to the persons' character, needs and interests. For example, some people enjoyed their hands massaged, songs and holding items given to them by their family or handling things with different textures. One person enjoyed talking about politics, American presidents and some animals. Staff encouraged them to talk, this helped their speech and also helped staff to tune into their verbal communication. Other people enjoyed art and staff spent time with them painting.

Staff were considerate and respectful when supporting the people in their care. Staff were friendly and unhurried in their approach, giving people time to process information and communicate their responses. Staff were aware that different people responded to different communication styles, they were consistent in the ways they spoke to people. For example, short sentences helped some people understand what to do, where as other people needed staff to use objects of reference and pictorial prompts to support them making choices. We observed staff were always mindful of people's independence and gave them the chance to do things for themselves before stepping in or prompting if needed. Care plans included guidance for staff to support people to do as many things for themselves as they could; we observed this happening during the inspection.

We observed many examples of positive interactions between staff and people, with staff showing respect and kindness towards the people they were supporting. Staff spoke respectfully and kindly about people between themselves when discussing how people's days were going and during staff handover.

Staff were able to describe each person's support needs accurately and tell us about them as an individual. Records of key worker meetings had been made and showed some people's involvement in them. Care plans had also been prepared with people's involvement and recorded discussions about what help they might need to understand information held in them. They were particularly well developed around choice, communication and pain assessment. This helped to ensure people were cared for and supported as they wanted to be.

Each person had a detailed pen picture. This included the most important things about them, the most important things to them and the most important areas where they required support. This provided detailed information for staff and helped to ensure staff were aware of these needs. Staff were knowledgeable about people's life experiences and spoke with us about people's different personalities. They knew what people liked and didn't like. Staff told us they had got to know people well by spending time with them and, where possible their relatives, as well as by reading people's care records.

Staff were careful to protect people's privacy and dignity throughout the inspection. They asked people if they were happy for us to visit their bedrooms and made us aware of anyone who preferred to keep their bedroom private. People said they had their privacy and dignity respected. Two people told us, "They knock on my door and wait to come in." People were dressed in clothes of their choice; they told us they felt clean and well cared for.

People were supported to maintain contact with their families and friends. The registered manager told us about garden and other social events to which people's families were invited.

Care records were stored securely when not in use; all information was kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to support this.

Is the service responsive?

Our findings

People felt staff knew what they liked and which activities, interests and subjects of discussion were important to them. People had regular activities and outings, some people told us this gave them an opportunity to see friends, make new friends as well as practicing some life skills. Some people told us this helped them to feel more confident. Engagement with wider groups of people for learning and social activities helped to ensure people did not feel socially isolated. The service had a mini bus available as transport for activities.

Although people felt the service was responsive to their needs and enjoyed activities provided, we found some examples of practice which was not responsive. Goal setting is an effective way to increase interest and motivation to enable people to create changes they may desire; it introduces a structured way of helping people manage and meet their expectations. We looked at how people's goals and aspirations were recorded and reviewed and how this linked to activity planning, development of learning and exploring new activities and challenges. Records showed reviews of goals were not well developed. In some cases goals were not set or it was difficult to see how issues people raised at previous reviews were progressed into the current review. Reviews completed did not evaluate existing goals where set and did not map actions needed to meet future goals.

Care and treatment was not planned with a view to achieving people's preferences and ensuring their needs were met. This was in breach of Regulation 9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not have any complaints and did not wish to make any. They told us they knew the staff and the registered manager by name and were confident that, if given cause to complain, it would be resolved quickly. The service was not dealing with any complaints and considered there were a variety of ways in which people could complain if the service was not meeting their expectations, including an 'Open door policy'. However, services are required to have a complaints procedure for people and any visitors to the service; it should be in an accessible format for people who may wish to use it. We spoke with the registered manager who confirmed although once in place, the complaints procedure was not displayed and could not be located within the service.

The provider had not established an effective accessible system for dealing with complaints. This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Completed pre-admission assessments ensured the service was able to meet people's individual needs and wishes. Care plans were developed from the pre-admission assessments as well as discussions with people, their relatives and the observations of staff. People were happy with the care and support received.

Care plans were presented with pictorial prompts to make them easier for people to engage with and understand. Some people had read their care plans and signed them agreeing with the content. Other people told us staff had gone through their care plans with them and they were happy with what they said.

Care plans contained details of people's preferred routines, such as a step by step guide to supporting the person with their personal care. This included what they could do for themselves, however small and what support they needed from staff. For example, the elements of personal care that people could do independently.

Care plans gave staff an in-depth understanding of each person and staff used this knowledge when supporting people. Care plans reflected the care and supervision provided to people during the inspection. Daily notes reflected what each person had done, their mood and any events of importance, for example visits from health care professionals or if a person had been unwell.

Care plans contained comprehensive and specific information, including input from health and social care professionals where necessary. This had helped to ensure specific conditions were monitored and appropriately reviewed so that the right support was provided. Specialist occupational aids were provided, for example, profiling beds ensured people were safe when they slept; an air flow mattress to help reduce the risk of pressure areas and individually designed orthopaedic chairs supported some people to sit safely and comfortably. Where people had specific conditions, for example, epilepsy, there was guidance for staff about symptoms or indicators which may precede a seizure and the support the person would need. Monitoring of seizures helped to inform medication reviews and to determine how well the epilepsy was managed.

Care plans were reviewed continually to ensure they remained up to date. Annual reviews were current and provided oversight of care provided. These were open to people's care manager, relevant person representatives, their family or an advocate and staff. People told us they thought they received the support they needed.

Is the service well-led?

Our findings

Staff and people were positive about the registered manager, describing them as "Approachable, supportive and fair." Staff said they enjoyed working in the service, they were proud of the support and care the provided and they felt valued by the registered manager. They described an open culture where they were encouraged to speak out with any concerns or ideas to improve the quality of the service being provided. However, although everybody was positive about the service, we identified some shortfalls which meant it was not always well led.

Auditing and checking procedures were in place within the service. The registered manager and regional locality manager undertook regular checks of the service to make sure it was safe and people received the support they needed. These included areas such as infection control, medicine management, nutrition, mobility, care plan quality and building maintenance. Although checks had identified, in particular, items requiring maintenance, replacement or repair, the quality assurance framework was not fully effective. This was because time frames were not always set to ensure required work was completed. Medication audits had not recognised or put measures in place to resolve areas where regulations were breached. These included an incomplete record for the return of some medicine. Therefore, systems had not ensured continuous and effective oversight of all aspects of the service.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and maintain complete and contemporaneous records was a breach of Regulation 17(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes when a service receives a decision from local authorities in response to an application made under Deprivation of Liberty Safeguards. This is where restrictions are needed to help keep people safe in the service. Statutory notifications informing us about two decisions had not been made to the Commission.

The registered person had not notified the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 4(A)(a) of the Care Quality Commission (Registration) Regulations 2009.

Established systems sought the views of people, relatives, staff and health and social care professionals and were due to be undertaken for the current year. People had completed questionnaires about their opinions of the service; sometimes with the help of their key worker. Questions covered staffing, choices, feeling safe and being listened to, and the responses were positive overall. The service had a variety of methods by which to measure the standard of care and people's experiences of it, including one to one meetings and discussions with people's families.

The service published its aims and objectives within a personalisation strategy. This was available in the entrance of the service and set out 'What success looks like, How we deliver success and How we know how

well we are doing'. Staff understood the vision of the service, one member of staff commented, "It's our job to make sure people enjoy as much independence as possible but have our support when they need it".

Staff told us and records confirmed the culture within the service was supportive and enabled staff to feel able to raise issues and comment about the service or work practices. One member of staff commented, "It is a very open culture here, I feel able speak out about anything, we have a good team". Other staff told us, if needed, they felt confident about raising any issues of concern around practices within the service and felt they would be supported by the registered manager and provider.

The registered manager told us the values and commitment of the service were embedded in the expected behaviours of staff and were discussed with staff and linked to supervisions and appraisals. Staff told us the values and behaviours included supporting people to make choices, clear communication, transparency, honesty and integrity. Staff recognised and understood the values of the service and could see how their behaviour and engagement with people affected their experiences living at the service. Staff displayed these values during our inspection, particularly in their commitment to care and support and the respectful ways in which it was delivered.

People knew the different roles and responsibilities of staff and who was responsible for decision making. Observations of staff interaction with each other showed they felt comfortable with each other and there was a good supportive relationship between them. Staff felt they worked together well to achieve positive outcomes for people, for example, discussing outings or the health of a person who was agitated and suggested actions.

Policy and procedure information was available within the service and, in discussion; staff knew where to access this information and told us they were kept informed of any changes made.

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 registered person had not notified the Commission of events which they had a statutory obligation to do so. Regulation 18 4(A)(a) of the Care Quality Commission (Registration) Regulations 2009.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not planned with a view to achieving people's preferences and ensuring their needs were met. Regulation 9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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 not ensured the proper and safe management of medicines. Medicines were not stored appropriately or recorded as disposed of safely. Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises and

equipment used by the service was properly maintained. Maintenance arrangements had not ensured identified concerns were suitably addressed. Regulation 15 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints</p> <p>The provider had not established an effective accessible system for dealing with complaints. Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems and processes failed to assess, monitor and improve the quality and safety of services and maintain complete and contemporaneous records. Regulation 17(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>