Choice Support

Renhold Community Home

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?	**Requires Improvement**

Summary of findings

Overall summary

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

Renhold Community Home accommodates up to 5 people with a learning disability in one adapted building. There were two people living at the home during this inspection.

The accommodation is single storey and was accessible for people who may also have a physical disability. This showed the care service had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection of this service in October 2015, the home was rated Good.

During this inspection, which took place on 13 February 2018, we found a number of breaches of regulations and areas requiring improvement. Therefore, on this occasion, we have rated the home as Requires Improvement. This is the first time the service has been rated Requires Improvement.

People were not adequately safeguarded from potential abuse. Staff supported people to manage their finances, because they had been assessed as not having the capacity to manage their own finances. We found there was a lack of clarity about what people were expected to pay for. As a result people had spent money on items and activities that had not been legally agreed. This meant that the home had not always acted in line with legislation and guidance relating to people's consent.

In addition, the service had failed to report a potential area of abuse to the local authority's safeguarding team, as required. They had also not reported certain notifiable incidents to us, the Care Quality Commission (CQC).

There were sufficient numbers of suitable staff during the day to keep people safe and meet their needs. However, the provider needed to review the arrangements for staffing at night, to ensure people's needs could always be met in a safe and timely way.

The provider carried out checks on new staff to make sure they were suitable and safe to work at the home.

We found some gaps in the checks that had been undertaken, meaning that not all legally required checks had actually been carried out.

In general, people received their medicines when they needed them. However, on the day of the inspection an error occurred. Staff took swift action to ensure the person involved was safe but work was needed to prevent this from happening again.

Opportunities for the service to learn and improve were sometimes missed, because information had not been shared at provider level. Quality monitoring systems were not sufficiently robust, because they had failed to highlight the areas we identified for improvement during this inspection.

Processes were in place to ensure risks to people were managed safely. The home was also clean and systems were in place to make sure people were protected by the prevention and control of infection.

Appropriate referrals were made to external services, to ensure people's care and support was delivered in line with current standards and evidence –based guidance.
People were supported to have enough food and drink to maintain a balanced diet. Risks to people with complex eating and drinking needs were being managed appropriately.

People had access to healthcare services, and received appropriate support with their on-going healthcare needs.

The building provided people with sufficient accessible space and modified equipment to meet their needs.

Staff provided care and support in a kind and compassionate way. People were encouraged to make decisions about their daily routines. This meant that people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's privacy, dignity, and independence was respected and promoted. They received personalised care and were given opportunities to participate in activities, both in and out of the home.

Arrangements were in place for people to raise any concerns or complaints they might have about the home.

Systems were in place to support people at the end of their life to have a comfortable, dignified and pain free death.

Arrangements were in place to involve people in developing the service through a variety of different ways. The service also worked in partnership with other agencies where needed, for the benefit of the people living there.

After the inspection we attended a meeting with the provider and the local authority, to discuss some of the issues found during the inspection. The provider was well prepared for the meeting and set out a number of positive changes that they intended to make to address the concerns raised. They also sent us an action plan setting how they planned to make these changes. We will carry out another inspection in due course, to check their progress with this.

Further information is in the detailed findings below.

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 adequately protected from abuse. This was because the arrangements in place to support them with their finances, and for staff to report potential safeguarding incidents, were not sufficiently robust.

There were enough numbers of staff to meet people's needs during the day. Further action was required from the provider to ensure this was also the case at night.

Due to a medicine error, further action was needed to ensure people received their medicines safely and as prescribed.

Risks to people were assessed and managed appropriately.

People were protected by the prevention and control of infection.

When things went wrong, lessons were learnt in order to improve the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Best interest decisions were not consistently made on behalf of people in accordance with legislation.

Appropriate referrals were made to external services to ensure people's care and support was delivered in line with current standards and evidence –based guidance.

Staff supported people to access a variety of healthcare services to promote their day to day health and wellbeing.

People were supported to eat and drink enough.

People's needs were met by the adaptation and design of the premises.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

Staff supported people to express their views and be involved in making decisions about their care and support as much as possible.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Systems were in place to ensure people's concerns and complaints were listened and responded to.

If needed, arrangements could be made to ensure people at the end of their life were supported to have a comfortable, dignified and pain free death.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to monitor the quality of service provision, in order to drive continuous improvement, were not effective.

Legal requirements were not always followed such as reporting notifiable incidents to us, CQC.

Opportunities for the service to learn and improve were sometimes missed.

A registered manager was in post.

Arrangements were in place to involve people in developing the service.

The service worked in partnership with other agencies for the benefit of the people living there.

Renhold Community Home

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 comprehensive inspection was unannounced and was carried out on 13 February 2018 by one inspector.

Before the inspection we checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also asked for feedback from the local authority who have a quality monitoring and commissioning role with the home. After the inspection we met with the provider and the local authority to discuss some of the findings from the inspection.

During the inspection we used different methods to help us understand the experiences of people living at the home because some people had complex needs, which meant they were not able to communicate with us using words. We learnt from speaking with staff and looking at records that people were dependent on staff to support them in all areas of their lives.

We spoke with or observed the care and support being provided to both people living at the home during key points of the day, including meal times and an activity session. We also spoke with the registered manager, deputy manager and five support workers.

We then looked at various records, including care records for both people living at the home, as well as other records relating to the running of the home. These included staff records, medicine records, audits

and meeting minutes; so that we could corroborate our findings and ensure the care and support being provided to people was appropriate for them.

Requires Improvement

Is the service safe?

Our findings

People were not always safeguarded from possible abuse. Both people living at the home had been assessed as not having capacity to manage their finances. Records showed that the provider was corporate appointee for each person, and that staff managed day to day financial transactions on their behalf. For example, buying toiletries, paying for leisure activities and transport. We saw that clear records were being maintained for all financial transactions, which were supported by receipts. However, we noted that where people shared costs, such as for activities, the amount they paid varied, depending on how many people were involved in that activity. One example of this was the cost of a regular music session provided by an external musician. Records showed that people were paying almost £7 more for this activity than they had been four months previously, due to the number of people living in the home reducing in that time.

In addition, we found that people were expected to pay for items necessary for maintaining their own personal hygiene and continence needs, such as wipes and bed pads. There was no evidence that they had agreed to this and the registered manager confirmed that there was nothing in writing that set out clearly what the home paid for and what people were expected to pay for.

Meetings had been held to discuss whether some of the purchases made on behalf of people were in their best interests, such as the music sessions. However, these had not been reviewed or updated since the number of people living at the home had decreased. This meant that people had been placed at risk of possible financial abuse because the systems in place to support them with managing their money were not sufficiently robust. After the inspection, we made a safeguarding referral to the local authority based on our findings. This is because the local authority has a statutory responsibility to protect people experiencing or at risk of abuse.

In addition, we identified that a medicine error had taken place during the inspection, where one person had been given another person's medicine, but had not been given their own. Staff took proper steps to ensure the safety and wellbeing of the person who had been given the wrong medicine, including contacting the person's GP. However, they failed to notify the local authority's safeguarding team about the error. This was confirmed by the registered manager and the local authority. The most recent local safeguarding procedures for Luton, Bedford Borough and Central Bedfordshire state that failure to give prescribed medication to someone is a potential act of neglect. It goes on to say that when an employer is aware of abuse or neglect in their organisation, then they are under a duty to inform the local authority and a safeguarding concern must be raised.

These were all breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we attended a meeting with the area manager and registered manager for the home, and the local authority, to discuss the concerns found during the inspection. The provider undertook to make several changes including the supply of all essential items relating to personal care for people living at the home. They also agreed to refund one person for the items they had paid for in order to maintain their

personal hygiene and continence needs. In addition, they committed to ensuring all staff were made aware of the need to report any medicine errors in future.

The registered manager outlined the processes in place to ensure that safe recruitment practices were being followed; to confirm new staff were suitable to work with people using the home. We were told that new staff did not take up employment until appropriate checks were in place such as: proof of identity, references and a satisfactory Disclosure and Barring Home (DBS) certificate. We looked at a sample of staff files and found that the majority of required checks were in place, but some were missing. This included details of two staff member's full employment history and an explanation for any gaps in that history.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the management team advised that this had been raised with the organisation's HR (Human Resources) department, who took the lead responsibility for staff recruitment.

The registered manager told us staffing levels were planned to meet the assessed needs of people. Both people living at the home required two members of staff to assist them with their mobility. During the day we observed there to be up to five members of staff, including the registered manager. This meant that people received care and support when they needed it and in a timely manner. For example, at meal times there were enough staff to assist both people to eat at the same time, so they were not left waiting.

At night time, however, staff informed us that there was only one waking member of staff on duty. This meant that people would need to be in bed before the day staff left the building at 21:30. We were concerned that this arrangement did not enable people to have a choice about when they went to bed. In addition, we questioned whether these arrangements were sufficient in terms of someone becoming ill and requiring additional support during the night. The registered manager told us that this routine suited the current needs of the people living at the home but added that the rota was flexible so, if people had a need or wanted to go to bed later, this could be accommodated. She also said that there was an on-call manager available for additional support. She explained that the waking member of staff used a 'roll method', to meet people's care needs whilst they were in bed. At the meeting with the local authority the provider agreed they would review the night time staffing risk assessment for the service and ensure this was kept under constant review, based on the needs of the people living at the home.

Systems were in place to ensure the proper and safe use of medicines. However during the inspection a medicine error did occur. Staff were observed taking swift and appropriate action to deal with this and ensure the person involved was safe. It was clear from their actions that there were established processes to follow in the event of an error happening. The registered manager stated that there had been no other errors within the past 12 months and this had been a one off. We checked a sample of medicines and medication administration records (MAR), and found these to be in good order. The registered manager advised that steps had been taken to minimise the risk of this happening again including the separate storage of people's medicines. In addition, there were plans to retrain staff. We saw from records that competence checklists were carried out for each member of staff to ensure they were safe to administer medicines to people, and these were reviewed annually. Other records showed that people had their medicines checked at appropriate intervals, to ensure they were only taking what was necessary to maintain their health and wellbeing.

Risks to people were assessed and managed safely. Staff spoke to us about how risks to people were assessed to ensure their safety and protect them from harm. They described the processes used to manage

people's identifiable risks such as seizures or choking. This information had been recorded in people's care plans, providing a clear record of how the risks to individuals were being managed in order to keep them safe. For example, personalised guidelines had been developed detailing how staff should support people with eating and drinking; to minimise the risk of choking. We observed these guidelines being followed by staff during the inspection.

Systems were in place to ensure the premises and equipment was managed to promote the safety of people, staff and visitors. We saw that routine checks of the building were carried out along with servicing of equipment and utilities on a regular basis.

People were protected by the prevention and control of infection. The registered manager confirmed that care staff were responsible for cleaning, and showed us how tasks were divided out across the week. We observed the home to be clean and free from offensive odours.

Records showed that staff responsible for preparing and handling food had also completed food hygiene training.

Lessons were learned and improvements made when things went wrong. We spoke with the registered manager about a number of incidents that had brought about changes at the home. An example was dysphagia training for staff following the death of a person, outside of this service, from choking. Both people living at the home had been assessed as being at risk in terms of swallowing and choking, so this training had been arranged to raise awareness amongst staff and minimise the risk of a similar event happening.

Requires Improvement

Is the service effective?

Our findings

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. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA. We found that systems were in place to assess peoples' capacity to make decisions about their care, and DoLS applications had been completed where appropriate.

Records showed that best interest decisions had been made regarding people's finances and what they spent their money on. However, these lacked detail about the actual cost of expenditure being discussed and had also not been updated to reflect recent changes in how people's money was being managed. We noted too that only staff from the home had attended the meetings, which meant there was a lack of objectivity around the decision making process. On another record, only a member of staff had signed a form which set out how much the person was to pay towards staff costs if they accompanied them on an outing. No one has any legal authority to agree to financial arrangements on behalf of a person unless there are appropriate LPA (Lasting Power of Attorney) arrangements in place. Staff confirmed that neither person living at the home had LPA arrangements. This meant that best interest decisions were not consistently being made in accordance with legislation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, the registered manager showed us that best interests meeting records had been updated for both people living at the home regarding the costs they shared for a visiting musician. These were well put together and included clear input from the families and the musician; providing some objective feedback to evidence that the cost of these sessions was deemed to be in people's best interests.

Staff were consistently seen patiently encouraging people to make their own decisions and seeking their consent before providing care and support. One person made it very clear through moving their head that they did not want a cold drink after eating their evening meal. This was respected by staff and a hot drink was provided instead, which was received well by the person.

Where DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) arrangements were in place, there was evidence that these had been discussed with people, or their relatives - where appropriate, and their involvement recorded.

People experienced a good quality of life because staff ensured their care and support was delivered in line

with current standards and evidence –based guidance to achieve effective outcomes. The registered manager told us that people's care and support was regularly reviewed and updated, with appropriate referrals made to external services such as the community OT (Occupational Therapist) and a dementia specialist. Records we looked at supported this.

Staff had the right skills and knowledge to deliver effective care and support. We read some positive written feedback from a member of staff following some training they had attended. They had written: 'Training showed us examples of how to better involve people in their lives. We watched films and thought of the people we support, I came back with fresh eyes'. A bank member of staff told us they received the same training as permanent staff.

The registered manager talked to us about the home's approach to staff training. Training records were being maintained to enable them to review completed staff training and to see when updates or refresher training was due. These confirmed that staff had received recent training that was relevant to their roles covering areas such as: dementia, epilepsy, diabetes, nutrition and wellbeing, communication with people with profound disabilities, risk management, end of life, infection control, medicines, safeguarding, fire safety, moving and handling, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We observed staff using their training effectively in the way they provided care and support to people throughout the inspection.

Staff confirmed that meetings were held to enable the team to meet as a group, and to discuss good practice and potential areas for development. Recent records showed that areas such as after support to a relative following a person's death, training and choking had been discussed. Other records showed that staff had received individual supervision; providing them with additional support in carrying out their roles and responsibilities.

People were supported to eat and drink enough to maintain a balanced diet. Staff demonstrated that they understood how to support people with complex needs in terms of eating and drinking. They were knowledgeable about who was at risk of choking or from not eating and drinking enough. We saw that they used soft and chopped food or thickened drinks, to aid swallowing. People appeared to enjoy their meals as they were seen to eat well. Staff assisted people, when required, to eat in a discreet and relaxed way.

Menus did not offer a choice as such because there were only two people living at the home however; we saw that meals were prepared according to the needs and preferences of each person. We also saw that people were given options, such as two different types of juice to choose from.

Staff confirmed that the home had developed positive working relationships with external services and organisations in order to deliver effective care, support and treatment to people. For example, we were told about a learning disability liaison nurse based at a local hospital, who worked with the service when someone living there needed to go to hospital.

People were supported to have access to healthcare services and receive on going healthcare support. We saw some feedback from a relative who had written: 'We are so pleased with how well [the person] is being looked after and how well her mental attitude and physical appearance has improved so much since moving here'. People living at the home had complex needs, which required regular access to a variety of medical and healthcare professionals. We saw that each person had their own health plan; to aid staff in supporting them to meet people's health needs. The records contained clear information about people's healthcare needs, and demonstrated that they had regular access to healthcare professionals, who supported them in monitoring and managing long term health conditions.

People's needs were being met by the adaptation, design and decoration of the premises. Both people living at the home used a wheelchair to mobilise. We saw that they had sufficient space to access communal and individual areas within the building, as well as a spacious garden. Modifications had been made to provide equipment such as overhead tracking, specialist bath, a low rise sink and adjustable height work surface in the kitchen; to meet people's specific needs and promote their involvement and independence as far as possible. There was homely feel in terms of how individual and communal areas had been decorated and personalised to reflect the individuality and preferences of the people living there.

This demonstrated that the home worked in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion; enabling people with learning disabilities and autism to live as ordinary a life as any citizen.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. Although they were unable to tell us if staff treated them well, we observed positive interactions throughout the inspection. Staff were attentive and inclusive, and people appeared comfortable in their presence. It was clear that people felt at ease with the staff and they expressed their happiness and contentment in a variety of ways such as laughing and smiling.

Staff understood the best way to communicate with people. They explained that they looked for facial expressions and visual clues, such as how one person turned their head to show whether they were engaged with an object or activity. We heard how they used simple verbal prompts and objects of reference to support people's choice and involvement. People were not rushed and were given time to respond. It was clear from the calm atmosphere at the home that people felt relaxed and happy with this approach.

We saw that a one page profile was in place for each person living at the home. These made reference to their skills and talents, likes / dislikes as well as other useful information about them. This would be helpful for new staff in order to be able to communicate with people in a meaningful way and to understand some of their key support and communication needs.

People were continually supported to express their views and to be actively involved in making decisions about their care and daily routines. Staff talked about taking part in a pilot process for the organisation called Person Centred Active Support (PCAS). They told us that PCAS aimed to help people with very complex physical and sensory needs to develop involvement and control in their own lives, by involving them more in their daily tasks and by maintaining their daily living skills. We read some feedback from a member of staff who had written: 'I never knew [the person] could do it. We need to think more about involving people'.

On our arrival staff explained some of the ways in which they supported people to get involved in daily activities. During the inspection we observed this happening when we saw people sitting in the kitchen whilst staff prepared meals or cleared away, so that they could participate in the sensory experience of these activities. It was clear from our observations that this approach was embedded in daily life at the home, and people were relaxed and appeared happy to be involved in this way.

Staff were heard offering people choices throughout the day such as what they ate and how they spent their time. For example, one person was asked whether they wanted to go out shopping. The person was seen smiling and making excited noises in response, indicating that they were more than happy to go shopping.

Staff told us that people received support from their families, who acted in their best interests to help with making more complex decisions. Records we looked at supported this. Alternatively the home had access to local advocacy services that were able to provide independent support and advice if required.

People's privacy, dignity and independence was respected and promoted. At meal times, staff provided appropriate help to protect people's clothing and to maintain their hygiene and dignity, and we observed

staff addressing people by their preferred name.

People's relatives and friends were made to feel welcome and were able to visit without restriction. We read some feedback from a relative who had written: 'The staff are absolutely brilliant; we feel part of one happy family'. Other records contained feedback from a relative which stated: 'Always made to feel welcome and feel staff do their best for [name of person].'

Throughout the inspection staff shared information about people with sensitivity and discretion, ensuring that at all times; their right to confidentiality was upheld. The registered manager told us that recent changes had taken place to ensure people's data was more securely stored and protected through new equipment and a password system.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People or those acting on their behalf, were encouraged to contribute to the assessment and planning of their care through face to face meetings, telephone calls and written information. This information was used to support staff in developing care plans that reflected how people wanted to receive their care and support.

Care plans we looked at were personalised and set out how each person should receive their care and support, in order to meet their individual assessed needs and personal preferences. Clear information had been developed setting out each person's preferred daily routines; enabling staff to meet their needs and provide care and support in a consistent way. There was an emphasis on encouraging people to do as much for themselves as possible, no matter how small that task might be. Other records showed that people's needs were routinely reviewed. This was to ensure the care and support being provided was still appropriate for them and that their needs had not changed.

We checked to see how people were supported to follow their interests and take part in social activities. We saw some feedback from a relative who had written: '[Name of person] is much more alert and getting out and about and is so much happier since coming to live here'. Staff talked to us about what each person liked doing, and it was clear they knew people's preferred activities well. These included listening to music, observing fish, spending time in the garden and going to the cinema. We observed some of these activities taking place during the inspection and noted from records that people were supported to take part in other activities that interested them. People living at the home shared the cost of a specially adapted bus which enabled them to access the local community and take part in external activities. Staff told us that people had built up strong links with the local community over the years and regularly attended coffee mornings at the village church.

During the inspection, an external musician provided some entertainment. The session was received particularly well by one person who became visibly animated in the lead up to and during the session. Staff really encouraged people to make the most of the session by playing percussion instruments with them, and by participating in the activity themselves.

Systems were in place for people's concerns and complaints to be listened and responded to. The registered manager told us that no complaints had been received in the last 12 months, but we saw that information had been developed to explain to people how to raise concerns or make a complaint, if they needed to do so.

We learnt from speaking with staff that arrangements could be, and had been in the past, made to support people at the end of their life; to have a comfortable, dignified and pain free death. We read some feedback from a relative that confirmed this. They had written: 'Thank you so much for the love, care and attention you have given [name of person] over the last few years. We were pleased he was able to die in his own bed with loving carers around him. Little Paddocks (the name the home is sometimes known by) is a very special place'. Records showed that staff involved people and their families in future planning, in order to establish

their wishes and preferences, should the need arise in the future.

Requires Improvement

Is the service well-led?

Our findings

During this inspection we identified a number of concerns regarding the governance framework for the service, in terms of how legal requirements were understood and met. This is because we found that notifiable incidents were not always being reported to us, the Care Quality Commission (CQC).

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

After the inspection, the registered manager confirmed that the notifications in question had been sent to us and this would be the case going forward. We checked our system and found this to be the case.

In addition, we saw quality briefings that highlighted incidents across all services run by the same provider, providing the opportunity for high level oversight of issues such as: medicine errors, incidents, falls and financial discrepancies; to identify potential patterns of concerns and enable information to be shared and lessons to be learnt across the board. However, during this inspection we found there was nothing in writing that set out clearly what the home was financially responsible for and what people were expected to pay for. This had resulted in people purchasing their own equipment and aids to support their continence needs. Approximately a year earlier, we carried out another inspection of a service run by the same provider. During that inspection we found that a person had been charged by the provider for another essential item – bedding. Following that inspection, we made a recommendation that a policy was developed setting out clearly what people can be charged for. It was clear from this inspection that this had not yet happened because the recommendation had not been shared or acted on by the provider, in the best interests of the people using their services. This showed that opportunities for evaluating learning at provider level were not always used to drive continuous improvement and manage future performance.

The registered manager talked about the arrangements that were in place for the service to continuously learn, improve, innovate and ensure sustainability. She told us about the quality monitoring systems that were used to check the home was providing safe, good quality care. We saw evidence of regular audits taking place at both home and provider level, covering areas such as finances, the environment, care records, medicines, staff records and engagement. However, we were not assured about the robustness of the quality monitoring systems in place because they had failed to identify or act on the areas of concern that were found during this inspection such as: the lack of clarity about what the home paid for and what people were expected to pay for, failure to report a medicine error to the local safeguarding team, incomplete staff recruitment checks, best interest decisions not consistently being made in accordance with legislation and failure to report certain notifiable incidents to us, the CQC. This meant that the systems in place to monitor the quality of service provision, in order to drive continuous improvement, were not effective.

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

Since our last inspection in 2015, the same registered manager had remained in post, providing consistency

for the home in terms of their leadership. A registered manager is someone who is registered with the Care Quality Commission. 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 a service is run.

The registered manager explained she divided her time across two other services run by the same provider. A deputy manager was in place, who supported her with this on a day to day basis.

Staff we spoke with were confident and motivated. They were clear about their roles and responsibilities. We observed how they interacted with people and one another and found they worked collaboratively, in a caring, respectful and positive way.

The registered manager talked to us about how she ensured staff were supported, respected and valued. She explained that good practice was recognised through a thanks and recognition scheme organised by the provider called 'STARS'. We saw that the staff team for this home had been nominated for an award in 2016 and the registered manager had been chosen as 'Manager of the Year' in 2017. She explained she had been nominated by peers, staff and her area manager for the award. One member of staff talked about the registered manager and said, "I've learnt so much from her." They confirmed that they felt well supported by the area manager for the home too.

The registered manager explained that they actively tried to involve people and relatives in developing the service and that feedback was sought in various ways such as: satisfaction surveys, meetings and less formal interactions. Records supported this and we saw that recent tenant meetings had covered the following areas: the environment, activities, food, transport and staff changes.

We saw a report undertaken by a 'Quality Checker' in June 2017. Staff explained that Quality Checkers were people with a learning disability, employed by the organisation to carry out audits because of their first-hand experience of using services. The process was underpinned by the REACH standards - a set of voluntary standards about ensuring each person is able to live their life as they choose with the same choices, rights and responsibilities as other people.

The report contained positive feedback on many areas such as staff treating people with respect, one person being supported to stay in touch with friends from where they used to live, adaptations for people to maximise access within the building, the building being homely and clean, compatibility of people living together, seasonal menus, privacy and personalisation.

The registered manager told us, and records confirmed, that the home worked in partnership with other key agencies and organisation such as local multidisciplinary teams to support care provision, service development and joined-up care in an open and positive way. Where required, staff also shared information with relevant people and agencies for the benefit of the people living there.

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 Notifiable incidents were not always reported to us, the Care Quality Commission (CQC), as is legally required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Best interest decisions, made on behalf of people who lacked capacity to make their own decisions, were not always made in accordance with current legislation and guidance.

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 People had been placed at risk of possible financial abuse because the systems in place to support them with managing their money were not sufficiently robust. The provider also failed to report a medication error in line with local safeguarding procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Systems in place to monitor the quality of service provision, in order to drive continuous improvement, were not sufficiently robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People had been placed at possible risk from unsuitable staff because recruitment checks undertaken by the provider for staff working at the home did not include all the required checks.