Benell Care Services Ltd

Drayton Wood

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 10 and 14 March 2016.

Drayton Wood is a service that provides accommodation and personal care to people with a learning disability or autistic spectrum disorder. The home is registered for up to 37 people. It is not registered to provide nursing care. Accommodation is provided in five separate houses. On the days of our visit there were 36 people living in the service.

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

During this inspection we found four breaches of the Health and Social Care Act 2008 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.

People's safety had been compromised. Staff received training and were able to recognise signs of potential harm to people, but incidents were not always reported to the appropriate authorities. There were restrictive practices in place which were not always appropriate or respected people's freedom. Risks to people from the premises were not robustly managed and people's individual risk assessments were not always adequately reviewed. However, staff demonstrated they understood the risks to people living in the service and took action to manage them.

Medicines were not always administered safely. Records showed that there had been a number of medicine administration errors and incorrect practice. There was clear guidance for staff regarding medication administration and the medication we checked had been given appropriately.

There was a lack of understanding from staff and the management in the home regarding the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. We found people's capacity to make decisions was not assessed when required. When decisions were made on people's behalf the correct guidance and legislation was not followed.

Support provided to staff to meet people's needs was variable. Training was not always sufficient and some staff training was out of date. New staff received a full induction and the majority of staff we spoke with felt supported to meet people's needs.

People were supported to maintain their health, this included supporting people to eat and drink healthily. Staff knew people's individual dietary requirements. Risks regarding diet and nutrition were assessed and managed. Staff supported people to attend health care appointments and involved health and social care

professionals regarding people's care needs.

Staff appeared to know people living in the service well. They supported people to be as independent as possible. People received care from staff who were largely kind and compassionate, although people were not always treated or referred to in a kind way.

People's care did not always appear to be reviewed when required. People and their relatives did not always appear to have opportunities to review and discuss their care plans. People and their relatives felt able to raise concerns and complaints, actions were taken to address and resolve these promptly.

Meaningful activities were on offer that supported people's independence. People were supported to participate in activities of their choice and staff were proactive in supporting people to maintain important relationships.

Leadership within the home was not strong. There was a lack of guidance and support for staff. Staff were not always able to raise concerns and were not confident they would be protected if they did. There was a lack of systems for checking the quality of the service, this meant issues and areas for improvement had not been identified.

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.

Concerns about harm were not always reported and overly restrictive practices were in place.

Risks to people were not always managed. However, staff understood the risks to people living in the service and took action to manage them.

Medicines were not always administered safely. There was clear guidance for staff regarding medication administration and medication had been given appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a lack of understanding and application from staff and the management in the home regarding the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

People were supported to maintain their health through the involvement of health and social care professionals.

People were supported to eat and drink healthily. Risks regarding diet and nutrition were assessed and managed.

Is the service caring?

Requires Improvement

The service was not always caring.

People received care from staff which was largely kind and compassionate. However, some examples showed people were not always treated or referred to in a kind way.

People were supported to be an independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care did not always appear to be reviewed when required.

People and their relatives did not always have opportunities to review and discuss their care plans.

People and relatives were able to raise concerns and complaints, actions were taken to address and resolve these promptly.

People were supported to participate in activities of their choice and staff were proactive in supporting people to maintain important relationships.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff were not always able to raise concerns about the service and were not confident they would be protected if they did.

There was a lack of systems for checking the quality of the service, this meant issues and areas for improvement had not been identified.

Drayton Wood

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 10 and 14 March 2016 and was unannounced. The inspection was carried out by two inspectors and one bank inspector.

Before we carried out our inspection we looked at the information we hold about the service. This included notifications received by us. Notifications are changes, events, or incidents that providers must legally inform us about. We reviewed this information and information requested from the local authority safeguarding and quality assurance teams. We did not request a Provider Information Return (PIR) form. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During our inspection we spoke with six people living in the home. We spoke with the registered manager, deputy manager, training manager, seven members of care staff, and a member of staff responsible for maintenance. Not everyone living at Drayton Wood were able to speak with us and tell us about their experiences of living at the service. We observed how care and support was provided to people in the home. We spoke with one health care professional, a social worker from the local adult safeguarding team, and five relatives over the telephone.

We looked at three people's care records, medication records, three staff recruitment files and staff training records. We looked at other documentation such as quality monitoring, accidents and incidents and maintenance records. We saw compliments and complaints records and records from staff and residents' meetings.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with said they felt safe living in the home. One person told us they liked living at the home because staff, "Look after you" and, "Protect you." Relatives we spoke with felt people were safe.

We saw records that confirmed staff had received training in adult safeguarding. The staff we spoke with knew how to recognise and report avoidable harm and abuse. However, we found that concerns were not always consistently reported. One member of staff told us about an incident they had witnessed, but had not reported this. We looked at incident records that showed safeguarding referrals were not always reported when they should have been. The local authority safeguarding team confirmed not all referrals had been received and that safeguarding referrals were not always made. However, they said this had improved since a recent visit.

Staff told us and we saw records that showed some actions were taken which appeared unnecessarily restrictive. We saw one member of staff telling someone they could not cross the threshold of the office. A member of staff told us about an occasion when a member of the management team threatened a person with not being allowed to attend a social club in order to get the person to comply with them. A relative we spoke with said their relative was stopped from attending their club if they were, "Naughty." They said, "That's like stopping [their] life really." One person we spoke with said they sometimes felt they were treated like a child. They said, "I'm not a child and I don't like being treated like one." We saw one person's care had a number of restrictions placed on them. Their care plan said that they required 'staff around [them] at all times'. Their room was searched to ensure sharp objects were not kept in it. The care plan stated the objects should be removed or the bedroom door locked. Their night time care plan showed that their shoes should be removed from them to prevent them getting up at night and staff were to remind the person to stay in their bedroom till staff came to get them in the morning.

We felt the above information showed actions were not always taken to prevent or report harm. Some actions taken appeared overly restrictive and were not appropriate to managing the risks involved. We did not feel confident that staff would report safeguarding incidents or concerns. This meant people were not adequately protected from harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments had been completed to identify areas of risk for each person and how to reduce that risk. This included risks around behaviour, nutrition, finances, and medication. The majority of risk assessments that we looked at had not been reviewed in the last 12 months. The manager told us, when we asked, that they would expect these to be reviewed every six months.

We saw one person's care plan detailed the support they needed at night in order to keep them safe. This had been written in April 2015. It said the person could be active during the night and identified some of their activities would put them at risk. However, staff rotas showed there were no waking night staff in this

person's building. We asked the deputy manager about this and the actions needed to keep the person safe. They told us the care plan had not been updated and some elements of it were not correct. This meant that the person's risks were not being adequately managed.

Some risks to people from the premises were not adequately managed or risk assessed. We saw that in one building there had not been any fire evacuation drills since July 2014. This meant staff and people may not have known what to do in the event of a fire in this building. We spoke with the member of staff responsible for maintenance. They told us Anglian Water had carried out a site inspection in 2013 and provided advice in regards to managing the risks to legionella bacteria. They told us they had followed this advice, however there were no records to show this advice was being followed. There were no records to show that risk assessments or regular tests regarding legionella bacteria had been carried out. Other routine maintenance such as portable appliance testing and servicing of the lift had been carried out.

The above information meant that not all risks were regularly reviewed, managed or reduced. It also meant that new or agency staff did not have up to date guidance in the event that permanent staff were not available.

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

The staff we spoke with gave us examples of behaviour that might indicate an increased risk to the person and told us about actions they would take. For example, one member of staff said as soon as the person comes through the door, "I'll know what kind of mood they are in" and would adjust their behaviour accordingly. Another staff member told us how different types of behaviour could indicate different things for each person they supported. They gave us examples of this and the actions they would take as a result. One staff member told us how they had identified risks to a person from making hot drinks. They had taken actions to minimise this risk which involved the person and supported them to continue in a safer way. We concluded that staff knew the individual risks to people and took action to keep them safe.

We found medicines had not always been administered safely. Incident records showed that there had been a number of medicine administration errors. This had resulted in one person being given incorrect medicines three times within the space of one month. On another occasion medicines were incorrectly given to two people when staff carried out secondary dispensing. This practice involves one staff member preparing the medicines, while a second staff member administers the medicines. This is poor practice as the staff member administering the medicines was not doing so from the original container the medicines were supplied in and lead to errors being made.

We found that some homely remedies were out of stock. We asked the deputy manager what the procedure was for ensuring homely remedies were in stock. They told us there was not one. The registered manager stated that these medicines were not out of stock as they had some stored in their office. However, as these had not been recorded as received into the home, the stock count was not correct. A staff member told us that they would borrow medicines from another part of the home if their own stock level had run out.

These practices meant that people were not protected from the risks of unsafe use and management of their medicines.

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

We checked four medicine records and saw medicines had been correctly recorded. There was clear guidance in place for staff regarding the administration of people's medicines. This included medicines that should be administered when required (PRN). Medicines were stored appropriately; they were locked securely when not in use. However, prescribed PRN medicines and homely remedies were stored in a box with other equipment such as sample bottles, stickers, and patient information leaflets. This meant it was difficult to find anything quickly and easily.

We received mixed feedback regarding staffing. One person said, "There are enough staff to help me when I need them." Another person told us, "sometimes they [staff] are very busy and I have to wait for them." One member of staff told us that they felt additional staff might benefit the larger house and where people had higher communication needs. However, they told us they didn't feel a lack of staff impacted on people living in the service.

The registered manager told us people's level of dependency fluctuated and that a dependency tool to calculate the number of staff required was not used. They could not explain how staffing levels were managed in response to this. We had identified that in one house there were no waking night staff, even though care records showed that at least one person was awake and required supervision during the night.

The registered manager told us they worked on a basis that when all people living at the service were present there should be a minimum of 2 staff in each of the five houses. They said they tried to have three staff on for later shifts. However, the staff rotas we looked at did not always show this to be the case. A member of the management team confirmed that staff rotas were not always kept up to date with changes to staffing levels. On the days of our visit, however, we saw there were sufficient staff to meet people's care needs during the day.

This meant we were not confident that accurate staffing numbers were assessed or adjusted to take account of people's changing needs.

The registered manager told us they had their own bank staff but on some occasions they had used agency staff. They said they used the same person to ensure consistency. The agency staff were given a handover, floor plan and written information about people at the start of shift.

Safe recruitment practices were followed. The registered manager told us they checked gaps in employment history and applicants were tested on their literacy and numeracy skills. We checked three staff files which showed references and Disclosure and Barring record checks had been carried out.

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 the lack mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met.

Not all the staff we spoke with understood the MCA or DoLS. The training manager told us they were a, "Bit rusty." The registered manager gave us an example of using the MCA which did not follow the correct guidance. We looked at people's care records and saw that people had care plans which referenced their lack of capacity although no mental capacity assessments or best interest decisions were in place. For example, we saw one person's care plan stated they lacked capacity to manage their finances and the registered manager was their financial appointee. However, there was no information to show that the proper assessments to determine this or the most appropriate way to manage the person's finances in the way they would have preferred were in place.

We asked the registered manager if anyone was subject to a DoLS, they said they were not sure but did not think so. However, we identified that guidance for one person advised staff to take specific action to stop the person from leaving the building or accessing their room. We also saw that some people left the home during the day but were continually supervised by staff members during this time. One person's care records identified that the person required supervision from staff members at all times.

We were not able to find, and care staff were not able to show us, that records had been completed to properly show that people's mental capacity was assessed. Neither were there records to show that the requirements of the Mental Capacity Act 2005 and associated procedures had been complied with.

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

The staff we spoke with said they had received training however some staff raised concerns that the training was not sufficient. One staff member said they understood, "Most of it [the training]." Another staff member told us they had received training in MCA but that, "It didn't give me what I needed." We reviewed the training records. We saw that some staff had not received refresher training within the timescales recorded within the provider's system. The training manager told us they were in the process of carrying out a training need analysis. This would identify what training was required to meet the individual needs of people living in

each house. The training manager told us that training sessions were arranged and staff put their names forward. They said staff did not always attend and the management team were looking at a more effective way to manage this. The approach to training did not ensure staff were fully trained and competent to meet the needs of the people who use the service.

We received varying comments regarding the support provided by the management team, with some staff feeling better supported by some members of the team than others. One staff member told us they had asked the registered manager for support to manage a situation with someone living in the service. They said support was given but only when the member of staff had pushed for it. Staff said and records showed that formal supervisions were not always taking place, however records showed there were informal discussions with management that supported staff to meet people's needs.

There was an induction plan in place for new staff. Staff we spoke with confirmed they had completed an induction. Staff files we looked at showed an induction checklist was in place, this included policies, procedures, and training. Most of the staff we spoke with said they felt supported by their colleagues and management to provide effective care. One staff member told us they, "Get the right answers" from the training manager.

People were supported to eat and drink enough, and to maintain a balanced diet. All the people we spoke with were positive about meal times and the food. One person said about the food, "We can choose what we want." Another person said, "The food is lovely." Throughout our visit we saw people were encouraged to eat and drink. We observed members of staff gently encouraging people to prepare and eat their lunch. We heard staff asking people if they had enjoyed their meal and if they had had enough to eat and drink. Care plans contained clear guidance around peoples' nutritional needs and risks. People's weights were monitored when required. The staff we spoke with were able to tell us about people's individual dietary requirements. Two staff we spoke with gave us examples of how they supported people to eat healthily.

People were supported to attend their medical appointments. There was a system in place that kept a note of people's medical appointments. One person told us how staff took them to the hospital. Another person told us they saw the doctor, dentist, chiropodist, hygienist, and nurse. One member of staff told us how they had worked with the GP and the local Learning Disabilities team to ensure a person's health needs were met. Care records we looked at showed health professionals were involved in peoples' care. We spoke with a health professional who visited the home regularly. They told us the registered manager was good at communicating concerns about health.

Requires Improvement

Is the service caring?

Our findings

Most of the people we spoke with felt happy living at the home. However, one person told us staff could be, "Abrupt." Whilst there were some concerns we also saw staff treating people with kindness and compassion during our visits. One person told us, "They're always there when you need them." Another person said staff, "Were very kind." The relatives we spoke with told us they felt staff were caring. One said, "They go the extra mile." We saw one person was keen to share a funny story about their day with a member of staff. The member of staff took great care and patience listening to this story. When the story was finished they engaged in revelling in the humour with the person and sharing the experience. We saw staff took the time to listen to people and responded appropriately.

However, two members of staff we spoke with told us about some incidents they had witnessed that were uncaring. These included incidents where people were spoken to in a disrespectful and demeaning way in front of other people and staff members. Some of the records we looked at did not always speak about people in a caring and compassionate way. For example, we saw one record had been written in a subjective and judgemental way that was not respectful towards the person. Another record we looked at was written in an infantilising way and advised staff to take punitive action until the person changed their behaviour. These examples showed that people were not always treated in a respectful or kind manner.

The registered manager told us relatives were provided with opportunities to attend reviews of people's care and submit feedback. However, some of the relatives we spoke with said they were not involved in reviews or care planning. One relative said, "I didn't know if I could give my opinion." Another told us, "They had not had many reviews." We asked the registered manager how they supported people to be involved in decisions about their care. They told us people attended residents' meetings and one to one meetings. They said people had a choice in what toiletries and clothes they bought as well as how they spent their day. We saw people were able to spend individual time with staff during our visits. This gave people an informal opportunity to talk about their care. The people we spoke with felt they could make choices about their care. One person said, "We can do what we want, but I have to be supported." Another person said, "Get a say in what we want and where we want to go."

The staff we spoke with knew the people living in the service and spoke about them with affection and care. During the day we observed staff engaging with people who used the service and asked people how they wanted staff to give their care. They were knowledgeable about people and their needs. The care records we looked at showed people's views, interests and things that were important to them were recorded. The records included information about the person's life history, their preferences, cultural and spiritual needs, likes and dislikes and people important to them.

One person we spoke with gave us examples of how staff protected their dignity during personal care. Staff told us they knew how to protect and promote peoples' dignity. During the day we observed staff talking with people who used the service, they were polite and respectful. Staff knocked on people's doors before entering and doors were closed during personal care tasks. We saw staff discreetly and sensitively asked people if they wished to use the toilet. This meant people's personal dignity was respected and protected.

People told us they were supported to be independent. One person said, "They [staff] encourage me to do things for myself." A relative told us, "[Name] does a lot more for themselves then they ever did at home." We saw records that showed some people had specific time and help to support them with daily living skills and accessing the community. During our visit we saw people assisting staff with daily routines. This showed people were involved and supported to be independent.

Requires Improvement

Is the service responsive?

Our findings

We were not always confident people were receiving care and support that was responsive to their needs. Most care records we looked at showed clearly identified areas of support and how staff would provide this. Some care plans were individualised and contained information about people's preferences. However, not all plans were written in a way that reflected how people would prefer to be cared for or in a way that respected their preferences. Many plans had been written up to two years before our visit and we found that one person's care plan was not up to date. We reviewed daily notes for people which did not always show care plans were being followed. For example, one person's notes showed that staff members chastised a person for actions they had taken. The person's care plans advised staff to manage the actions in a different way to support their anxiety, although the notes did not show that these actions had been taken.

The home had paper care records and electronic care records. The two records did not always contain the same amount of detail. There appeared to be confusion amongst staff and management regarding which copies they followed. Some staff told us they followed the paper records whilst some said they followed the electronic plans. The deputy manager told us, "The updated ones are on the computer and the staff follow those ones." However, the registered manager told us the paper copies were followed. This meant we could not be sure staff were following the correct guidance for people's care.

A member of staff told us that they reviewed care plans with people when any changes occurred or every two to three months. However, the care records we looked at did not show that the plans were reviewed regularly. Some records simply had a date and a signature of the person however the majority did not have any evidence that reviews had happened. One person's records indicated they displayed behaviour that could challenge others and this had increased in frequency. There had been no review or evaluation of this care plan since April 2015. The registered manager told us there was an inconsistency in staff's performance in relation to completing care plan reviews. This meant we could not be sure that the information in care plans had been evaluated to make sure it was still appropriate.

During our visits we saw people were supported to participate in activities of their choice. One person we spoke with told us they had attended a Cliff Richard tribute event. Another said, "I go to the [name] club every week, I enjoy it." A relative told us, "[name] always has something to look forward to." We saw other people had been taken bowling and someone else was going shopping with a member of staff. The home accessed events in the community, the training manager told us that people attended local clubs and a specially arranged night club event. One person told us, "I go to Church with someone else." We saw records that showed each person had a clearly planned timetable of activities. This meant people were engaged in meaningful activities.

People were able to raise and share concerns. There were regular residents meetings. The minutes showed people were asked their views on holiday options as well as any other points or concerns. One person said, "I tell them [registered manager] how things are getting on." A relative told us they had raised an issue with a member of staff. They told us prompt action had been taken to address their complaint. We looked at complaint records that showed people had gone to the registered manager about their concerns. We saw

the registered manager had taken action to resolve these complaints. One record involved two people. The registered manager had taken action to meet with both people to listen to them and supported them to resolve the issue. We saw the registered manager followed up afterwards to check there were no further problems. This showed the registered manager took complaints seriously and worked with people in order to resolve them.

People told us they were supported to maintain relationships that were important to them. These important relationships were detailed in their care plan. Several people we spoke with told us about examples where staff had supported them to visit relatives. Relatives we spoke with said the home was supportive in maintaining contact.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. They were supported by a deputy manager and a training and HR manager.

Leadership did not always appear visible and there was an over reliance on other people to take action without checking to make sure this was done. For example, staff were expected to come to management if they required supervisions. The registered manager told us they, "Left supervisions as an open door policy, they come to us." There were no additional checks by management to ensure staff had supervision and as a result some people had not received this support for some time. The registered manager did not always know when servicing and maintenance checks were due. There was no system to check when servicing checks had occurred, for example to the lift, and consequently records to show this were not available. We were not confident this would have been identified without us asking. We discussed with a member of the management team what systems were in place to monitor quality and performance in the home. They said, "You're relying on people to bring certain things to your attention."

There appeared to be a lack of clear guidance and support for staff regarding their responsibilities and processes in the home. For example, not all incidents were reported to the registered manager and staff used inconsistent systems to record information or carry out reviews of care. The registered manager had identified some of these issues, although no action had been taken to address or improve them.

Records were not well maintained or accurate. The care plans and risks assessments were not updated within the time scales that the registered manager had told us. When talking about issues regarding care plans the registered manager said, "We could have a more robust view of care plans." However, we could not see that any action had been taken to address this. This meant issues we identified during our inspection had not been identified by the registered manager.

Accident and incident records were not analysed for trends or themes. They did not show what actions had been taken to mitigate the incident from happening again, such as making a referral to the local authority safeguarding team when appropriate. This had not been identified by the registered manager. Action had been taken to address medicine errors that had been reported in incident records. These included one of the management team undertaking checks on medicines twice a month and staff checked medicine administration records during their handover. We noted that there were no further incident records that detailed medicine errors since this had been started.

There was a lack of quality assurance processes and audits to effectively assess and monitor the quality of the service provided. We asked for copies of any audits or monitoring records that had been completed, but these were not available.

The training manager told us yearly questionnaires were carried out with people living in the service. However, relatives we spoke with said they had not been asked to provide feedback about the service. Questionnaire results showed that people were generally happy with the service they received, although

there were some suggestions for improvement. These had recently been carried out. We saw the registered manager had analysed them and identified actions to take in order to resolve any issues. We saw that there were regular staff and residents meetings. These gave people and staff opportunities to discuss the service, although not all representatives of people living at the home also received this opportunity.

However, the lack of quality monitoring records and actions to improve the service put people at risk as the systems in place were not adequate to identify issues and take the appropriate action.

The above information meant that there was a lack of good governance in the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers and registered managers are required by law to report incidents that can affect people's wellbeing by submitting statutory notifications to the Care Quality Commission. We saw that a number of safeguarding incidents had not been reported to us.

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

We received information prior to this inspection in regard to how the manager treated staff members. We found the culture of the home was not supportive towards all staff members or people using the service. During our inspection we had identified practices that appeared overly restrictive and paternalistic. One person was concerned about the actions that the management team would take if they knew they had raised some concerns.

We were also concerned that the culture of the home did not always foster clear communication of concerns from staff to the management team. There was conflicting information regarding the support provided by the management team. One member of staff told us, "The managers are supportive, if they have an issue with your work then they talk to you in private." However, another member of staff told us the registered manager shouted and swore at staff. Some staff told us that some of the management were not always approachable. We asked a member of the management team to give us an example of how management supported and protected staff. They told us staff were supported by building up their experience and not scaring staff regarding their responsibilities. They went on to suggest that they could reinforce the seriousness of medicine errors through telling staff that a medicines error which resulted in loss of life may mean a prison sentence for that member of staff. We saw staff meeting minutes that showed staff were told any medication error would result in a warning and possible disciplinary.

One staff member told us they were concerned that there would be repercussions from management. Another member of staff told us they were worried about the reaction from the management team if they found out negative information had been shared with us.
The above information meant we were concerned that the culture of the home was not supportive and may result in staff not reporting errors and concerns to management.

We asked the registered manager how they oversaw what was happening in the service and made sure staff were doing what they should. They told us they read the electronic care records and two other managers visit each building in the morning. The registered manager told us they relied on emails to communicate with staff and staff could email concerns. We were concerned that the registered manager did not appear to have a presence around the home and this would impact on their awareness of the day to day practice and culture within the home.

People and their relatives told us that they were happy with the care staff and how they acted. Staff

members said they worked together in each house but also across the home. One staff member told us, "I love working with the staff. We all work as a team. We support each other."

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 did not take formal enforcement action at this stage. 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 persons had failed to notify the Commission of adult safeguarding incidents that had occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not up to date and were not reviewed within the expected time frames. Risks to people, including risks from the premises were not managed. Medicines were not administered safely. Regulation 12 (2) (a), (2) (b), 2 (d), 2 (g).

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 Actions were not always taken to prevent or

	report harm or abuse. People were subject to inappropriate restraint that was not proportionate to the risk involved. Regulation 13 (1), (3), (4) (b), and (5).
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of suitable systems for assessing and monitoring the quality and safety of the service. Regulation 17(1), (2)(a), (b), (c) and (f).