Mrs Deborah Ann Plant

Community Living Project

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

Summary of findings

Overall summary

We inspected the service on 27 June 2016 and the visit was unannounced.

The Community Living Project is a registered care service providing care and support for up to eight people who have a learning disability. At the time of our inspection six people were using the service. The accommodation is offered over two floors. There is a communal lounge and dining room on the ground floor along with some of the bedrooms, and the remaining bedrooms are on the first floor. There is an accessible garden for people to use should they wish to.

The service does not require a registered manager. There was a manager in place who was spending less time working at the home. They had made arrangements for an acting manager to run the service on a day-to-day basis. The manager told us that the acting manager would be submitting an application to become the registered manager.

Relatives had no concerns about their family members' safety. Staff knew how to protect people from abuse and avoidable harm. The provider did not always have robust records where incidents had occurred. The provider was not always routinely checking the equipment and the premises to keep people safe.

The provider had managed risks to people that they were vulnerable to. For example, where people used the kitchen to make drinks and snacks there were clear instructions for staff about how to support people to stay safe.

We found that staffing levels were adequate to meet people's safety needs. The provider recruited staff safely.

People's medicines were stored safely but not always stored correctly. For example, one person's medicines were not stored at the correct temperature. Staff received regular guidance on how to administer people's medicines and were trained.

We identified a breach of the regulation where the service had failed to act in accordance with the provisions of the Mental Capacity Act (MCA) 2005. Staff did not always understand the requirements of the MCA and people's consent to care and support had not always been recorded. Where people may have lacked the capacity to make their own decisions, the provider had not followed the requirements of the MCA. For example, mental capacity assessments were not in place.

People were supported by staff that had received regular training and support. For example, staff had received training in supporting people with epilepsy.

People were satisfied with the food offered to them. Where there were concerns about people's health and well-being the provider had sought additional support.

People said that staff were kind and we saw staff supporting people in a caring manner. People's dignity was not always upheld. This was because some terminology in records could have been seen as not showing respect for people.

The provider had not documented how people had been involved and contributed to the planning and reviewing of their care and support. Information on independent advocacy services had not been made available to people to support them to speak up if they had required this.

Staff knew about people's preferences and what was important to them. For example, staff knew how people communicated. People were supported to maintain relationships that were important to them.

The service was responsive to people's needs and preferences. For example, the provider was installing a new bath for a person whose needs were changing.

People's support plans contained person-centred information and focused on them as individuals. We saw that staff worked in a person-centred way with people.

People had access to activities and interests that were important to them. For example, we saw that some people accessed a local day centre and some people had enjoyed a recent trip to a local zoo.

The complaints procedure was available to people and relatives knew how to make a complaint should they have needed to.

People and their relatives had opportunities to give feedback about the quality of the service. For example, people attended residents meetings to give suggestions to the provider about activities.

Relatives described the service as well-led. There was a shared vision of the service by the managers and staff members. This included promoting people's independence.

The manager was mainly aware of their responsibilities. However, the required notifications to CQC had not always been submitted. The provider had some quality checks of the service in place. However, these had not been effective in identifying some of the concerns we raised during our visit. For example, the medicines check had not identified that one person's medicines were stored incorrectly.

Staff told us that they were supported and we saw that the provider had processes in place to make sure that this occurred. Staff understood their responsibilities including reporting the poor practice of their colleagues should they have needed to.

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 consistently safe.

Staff knew how to protect people from abuse and avoidable harm although records were not always complete.

There were enough staff to meet people's needs and the provider's recruitment processes were robust.

People's medicines were not always stored correctly.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was not working to the principles of the Mental Capacity Act 2005 and staff did not have the required knowledge about it.

People received support from staff who had received regular training and guidance.

People were satisfied with the food and drink offered to them and they were supported to maintain their health and well-being.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider had not recorded how people were involved in planning their care where they could. People had not been given information on advocacy services.

People were supported by staff who showed kindness. People's dignity was not always maintained.

People's preferences were known by staff.

Is the service responsive?

Good

The service was responsive.

The provider had reviewed people's support requirements. However, people's care records did not show how people or their representatives had contributed to this process.

People had support plans that were focused on them as individuals.

People undertook hobbies and activities that they were interested in.

Relatives knew how to make a complaint and staff knew when people may not have been happy with their care and support.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Staff felt supported and knew their responsibilities.

People and their relatives had opportunities to offer feedback to the provider.

The manager did not always submit the required notifications to CQC.

The provider had not effectively monitored the quality of the service.

Community Living Project

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.

The inspection visit took place on 27 June 2016 and was unannounced. The inspection team included an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, 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 reviewed information that we held about the service. This included information that we had received about the service as well as statutory notifications that the provider had sent to us. A statutory notification contains important information about certain events that they must notify us of. We also contacted the local authority and Healthwatch (the consumer champion for health and social care) to ask them for their feedback about the service.

We spoke with three people who used the service and three of their relatives. We also spoke with a relative of a person who was out during our visit. We spoke with the manager, the acting manager, the housekeeper and two support workers. We looked at the care records of two people who used the service and other documentation to see how the service was managed. This included policies and procedures, checks on the quality of the service that the manager had undertaken and health and safety records. We also viewed three staff files to check how the provider had recruited and the support in place for staff.

Requires Improvement

Is the service safe?

Our findings

Staff members knew their responsibilities to keep people safe from abuse and avoidable harm. One staff member told us, "If I notice anything concerning I would sort it out straight away. I'd call 999 if needed or the GP". Staff were able to identify the different types of abuse and knew the correct procedure to take should they have needed to. This was because the provider had made available to them a policy and procedure for dealing with abuse and avoidable harm. Staff told us, and records confirmed, that they had received training in safeguarding people from abuse. We saw that there were two incidents recorded in people's care records in the last three months that were possible safeguarding concerns. The recording of these incidents did not include what action the provider had taken or the results of any investigation. We discussed this with the acting manager who was unclear of what action had been taken but advised us they would discuss the incidents with the manager and refer to a social worker if necessary. For other incidents, including accidents, we found that the recording was thorough and any action taken had been recorded. This had included speaking with social workers where necessary. The manager told us that they did not currently analyse accidents as only a small number had occurred in the last 12 months. This meant that although staff knew their responsibilities, records did not always show what action had been taken to keep people safe.

People received the medicines they were prescribed. One person told us that medicines were available if needed. They said they have medicines, "When I get up and if I have back pain". Staff knew about the safe administration of people's medicines and described how they offered people privacy to take it where this was requested. We found this to be in line with the provider's medicines policy that was available to staff that also gave guidance for them on dealing with medicine errors. We saw that medicines were stored safely but we found that one person's eye drops were not stored at the correct temperature. This meant that the medicine might not have been effective. The acting manager told us that they would seek advice from their pharmacy. After our inspection, the manager told us that all staff had been reminded about the need to check the storage requirements of medicines. Some people required as and when required medicines for when they became anxious. We saw that there were clear instructions for staff on when these could be used and staff could describe them. One staff member told us, "You've got to know them. The more you know a person the more you know they might need it. Sometimes you can distract. We have protocols and you can say to yourself 'Am I right?'. We can check the protocol. We try and ask them if they want a tablet as some are aware of their conditions". We saw that these medicines had been offered to people in line with their support plans. However, on four occasions in one month there were no records of behaviour or anxiety that led to staff making this decision. The acting manager told us that these records should have been in place and that they would remind staff. We saw that staff were trained in handling people's medicines and the acting manager was regularly checking their on-going competency.

The provider was not always regularly checking the safety of equipment and the premises. For example, we saw that checks on the fire detection system had not taken place for the last two months. The acting manager told us that these should occur weekly and would arrange for these to be carried out as such. Before our visit, we received information of concern that the provider was not checking their vehicle that they used to offer transport to people who used the service. The manager informed us at the time that weekly vehicle checks were in place. The acting manager told us that these were not in place. This meant

that there was a risk that people were using a vehicle that was not regularly checked for its safety. The acting manager devised a vehicle checklist on the day of our visit. We found that the provider had regularly tested other equipment that could have caused harm to people. For example, the electrical and gas safety had recently been tested as well as tests to the water system.

People felt safe at the home and their relatives had no concerns about their safety. One relative told us, "Everything seems to be ok. We haven't had any worries. They phone with any concerns". Another relative said, "They do keep me informed by email. Anything more important they phone me. Only once he had a fall, a few years back now. They told me all about it. Oh yes he is safe".

Some people displayed behaviour that presented a risk to themselves and others. Staff told us how they used distraction techniques when people became anxious such as offering an activity or space and time on their own. We saw that there were behaviour management plans in place that staff could describe. For example, we read, 'I need a clear structured routine throughout the day. I can become very upset if things change or are not happening when they should be'. We saw that staff offered this person clear and structured information and support on the day of our visit.

Risks to people's well-being had been assessed and regularly reviewed. For example, we saw that for one person they often placed themselves on the floor. The risk assessment had guidance for staff to follow to keep the person and other people safe when this occurred. We also saw in people's care records that some people did not understand risks when using the kitchen. Measures had been put in place to keep people safe but also respected their rights to take positive risks. For example, we read, '[Person's name] has limited capacity but can make drinks and snacks with assistance and guidance'. This meant that the provider had managed risks to people to keep them safe whilst protecting their freedoms.

The provider was in the process of writing plans for people in case of an emergency. The acting manager told us that these would detail the individual support people would require in the event of a significant incident, such as a fire, that would require them to leave the building. The provider also had an emergency plan in place for dealing with a range of incidents that meant that people would have continued to receive a service. For example, we saw that alternative accommodation had been identified if the home became unavailable due to fire or the loss of utilities. We saw that people and staff had regularly practiced how to vacate the home. This meant that people would have received support to keep safe during an emergency.

People's relatives had no concerns about the staffing levels within the home. One relative told us "There are not so many people there now so there's enough staff and they take her out now and again". We saw that where people required one-to-one support this was occurring and found that people received the care and support they needed to keep safe in a timely manner.

Staff had been checked for their suitability to work with people before they started their employment. We saw that the provider had a recruitment policy in place that was followed. For example, we saw that the provider had obtained two references for each employee as well as undertaking Disclosure and Barring checks. The Disclosure and Barring Service (DBS) helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. Staff records confirmed that these checks had been undertaken. This meant that people were supported by staff who had been appropriately verified.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether staff were working within the principles of the MCA.

People or their representatives had not signed their support plans to show their consent to their care and support. However, where consent forms for the taking of photographs were in place these had been signed by people in the care records we viewed. The acting manager told us that people's care plans had been discussed with their families where possible. We discussed with the acting manager that only people legally authorised can make decisions on people's behalf. Where these were not in place, best interest decisions would have needed to have been made. In the documentation that we viewed best interest decisions had not been considered by the provider. This meant that people were at risk of not having their human rights consistently upheld.

Relatives told us that their family members did not have the capacity to make a full range of decisions for themselves. One relative said, "She needs help with understanding. She doesn't remember anything. When people say she understands – she doesn't. She can say what she likes. No big decisions on her own". Staff also told us that some people required the assistance of others to make decisions on their behalf. One staff member said, "Some people's understanding is limited. Mental capacity assessments are not in place but the acting manager is dealing with that". We found, and staff members confirmed, that people living at the home had varying degrees of capacity to make decisions for themselves. The provider had not assessed people's capacity to understand individual decisions although they had identified that there were concerns. For example, we read, '[Person's name] does not understand the importance of his prescribed medication' and, 'I do not understand money and I need people to help me to manage my finances'. The acting manager told us that the local authority were offering support to the provider to complete mental capacity assessments. However, this currently meant that there was a risk that people were receiving care and support that was not in their best interests.

The provider was using Close Circuit Television (CCTV) in communal areas for the security of people using the service and to monitor how they interacted with one another. We found that the provider had consulted with people's relatives about its use. One relative told us, "Yes they asked and we had no worries about that". Another relative said, "Yes I think she (the manager) did email me and I think I emailed agreement straight away". However, we could not see how people had been fully consulted and if they had the capacity to make this decision. The acting manager told us that they were due to undertake further consultation with people. We also found that there was no policy or procedure in place for its use, that referred to who had access to the recordings or for continually monitoring its effectiveness. When we spoke with the acting manager they made the decision to switch off the CCTV until they had considered our concerns.

Some staff had received training in the MCA. However, we found that this had not been effective. Staff could

not describe the principles of the Act. One staff member told us, "I don't really understand it" whilst another confirmed they had not received training in this area. After our inspection visit, the manager told us that they had arranged additional training in the MCA to support the understanding of staff.

Although the acting manager gave us assurances that they would look at people's consent to their care, to assess capacity where we found it to be missing and to provide additional training for staff, the risks to people were significant.

These matters were a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). We saw that the manager had made the appropriate applications to the 'supervisory body' (the local authority) where they were seeking to deprive someone of their liberty.

People were supported by staff members who had received regular training and guidance. One staff member told us, "Yes online training is there. For example, health and safety and food hygiene. The manager lets you know when it's needed". Another staff member said, "It's very good actually. If you want to do something specific the manager is very helpful". We saw that training records had documented that staff had received training in, for example, epilepsy, managing challenging behaviour and first aid. We saw certificates in staff files that showed training had taken place. Staff also had opportunities to receive guidance on their work from a manager. One staff member told us, "Monthly supervisions are useful. It gives you a chance to discuss. I can discuss anything". We saw that staff had individual meetings with a manager every two to three months as well as a yearly appraisal where they had received feedback on their work on what needed to improve or what had gone well. We also saw that a new member of staff was completing their induction and was undertaking the Care Certificate. This is an assessment that helps new staff to gain knowledge about how to support people effectively. In these ways staff had received the necessary knowledge and guidance to provide effective support to people.

Staff had the skills to communicate effectively. For example, we heard staff talk about people's changing needs in a knowledgeable way where a person was anxious. We also heard staff speaking on the telephone to health and social care professionals and they spoke about people needs in a confident manner. This meant that staff were able to carry out their roles and responsibilities in an effective way.

People were satisfied with the food offered to them. One person told us, "It's sausage, chips and beans for dinner. Pie is my favourite". They told us when it was on the menu and said they liked the food. We saw that the provider had a four weekly menu on display and contained meals that had been identified in people's support plans that they enjoyed. The menu was written and although one person could read this, others could not. The acting manager told us this was something they were developing to make sure that people could be more involved in planning the menu by the use of photographs. We also saw that people were offered drinks throughout the day.

The provider had identified where people had complex needs in relation to their eating and drinking. We saw that support plans were in place to support people to eat well. Specialist health support had been requested and support plans contained guidance for staff. For example, we saw that a speech and language therapist had written a plan for staff to support a person to reduce their risk of choking. The person had a soft diet and staff were able to describe the person's food requirements. Staff also told us about other

specialist support that had been made available to people where there were concerns about their nutrition. One staff member said, "I took a person to see a dietician to help them with their weight".

People had access to healthcare professionals when required. One person told us, "I go to the doctors. Staff take me, I can't go on my own". Another person was able to describe where their doctor's surgery was and that they attended appointments where necessary. We saw in people's care records that they had seen their doctor and the outcome of the appointment had been recorded. For example, where there were concerns from staff about a person's breathing, it had been recorded that their doctor had advised a reduction in the amount of cigarettes the person smoked. The person agreed with staff to a plan to reduce them. The acting manager told us that they were working with the local authority to write health action plans. These are documents that support people to be involved in decisions about their health care. This meant that people received support to maintain their health.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. For example, before our inspection the manager told us that staff sat with people to eat their meals together. We saw that staff sat in the main office to eat their meals. We also read some language in a person's care records and in the fire checking documentation that could have been perceived as lacking respect for people. For example, in a person's care records we read how a person was 'told' to put their nightwear on following an incident when they broke a plate. We spoke with the acting manager about this who said that they did not have concerns about staff members' practice and that they would discuss the terminology used with them and offer reminders.

We saw that parts of the home required upgrading. For example, some people's bedrooms needed redecoration as the décor was deteriorating and some furniture was old and looked tired. We also saw that the garden area required attention. For example, we saw an old mattress stored in a corner. We saw that there was some refurbishment taking place. For example, we saw that a wet room was being built for one person whose mobility had deteriorated and a bathroom was being refreshed. The acting manager told us that the provider was working to upgrade the home and we saw that this had been detailed in a recent newsletter for people and their relatives.

Where people could, it had not been recorded how they had been involved in decisions about their care. A relative told us that they had not been involved. They said, "I'm not involved in the care plan, I don't see it". We saw that staff had recorded people's needs and requirements for support. However, we could not see that people or their representatives had been involved. We did see that where people may have required additional support to make day to day decisions, such as choosing what food they wanted, this had been documented. For example, we read in one person's care records, 'Use simple instructions, short sentences and ask [person's name] to point to what he wants or use gestures'. Where people may have required additional support to make decisions, we found that advocacy information had not been made available to them. An advocate is a trained professional that can help people to speak up. In these ways the provider had not recorded how people had been involved in planning their own care and support where they could.

People were supported to be independent and to maintain their skills and abilities. For example, we read in one person's care records, 'I can wash myself fully but I need help to wash my hair'. Staff described how they supported people to choose their own clothing and how they spent their time. This meant that people were encouraged to retain their skills.

People were treated with kindness and compassion when receiving support. People told us that staff were kind. We heard staff using people's preferred name and spoke with them in a caring manner. For example, people were asked if they were satisfied with the food offered and offered them regular support to freshen up throughout the day. Staff showed that they were listening to people by taking action asked of them. For example, one person was asked if they wanted their lunch and the person declined this. The staff member respected this and made arrangements to store the person's lunch until they wanted it. We saw that staff had built positive relationships with people. We also saw that people and staff spoke to each other in a friendly manner and staff showed a warm approach towards people.

Staff knew about people's communication needs. One staff member told us, "Residents have different understanding. I would talk differently depending on their understanding". People's communication differences had been detailed in their support plans. For example, we read, 'It helps sometimes if you ask me to repeat what I said slowly'. We saw staff doing this when we visited. We also saw that people had communication passports. These help staff and others, such as healthcare staff, to understand how people communicate and how to spend time with them. We found that these were detailed and were written in such a way that staff and others, such as healthcare professionals, would have been able to communicate in ways that people understood. For example, we read, 'I will laugh and rub my hands and if I'm happy I will make a zzzzz noise'. Staff knew what this noise meant. This meant that staff were able to communicate with the people they supported.

Staff knew and could describe people's preferences. We heard staff talking about people in a person-centred way and focused on them as individuals. We saw that one person required their medicines to be given to them privately. Staff told us that they did not like their medicines given to them in front of others and described how they upheld the person's right for this to happen. This was in line with the person's support plan. We heard staff talk about people in kind ways. For example, we heard staff share information about the activities people had undertaken and enjoyed and how they preferred to spend their time.

People's relatives told us that they maintained contact with their family members. They said, "She rings me up or I'll ring, we speak all the times. Sometimes a few times in a day". Other relatives told us that there were no undue restrictions on visiting their family members.

People could be confident that their care records and sensitive information were treated confidentially. This was because staff knew how to store and share people's information carefully. For example, people's records were stored in locked cabinets and only accessed by those who were authorised to do so. We also saw that there was a confidentiality policy in place that was available to staff that gave them guidance on the processes to follow.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. One relative told us, "His mobility is decreasing but they do their best to keep one step ahead to be ready for him". A staff member also commented on this and said, "The resident is losing his mobility quite quickly, so the owner is keen to have everything ready to meet his needs". We saw that a new accessible bathroom was being installed to meet the person's changing support requirements. We found that people's care records had been updated daily about the support that had been offered or where it had been refused. For example, we read how people had sometimes declined to take part in activities. This meant that people were receiving support that was based on their needs and wishes.

People's care records did not show how they, where they could, or their representatives had contributed to the assessment or planning of their support. However, one person's relatives told us that their family member had contributed. They said, "He does have a care plan between him and his key worker. It's on his bedroom wall. I see it when I go. He tells me too. He is very happy with it". We also saw that people's support requirements were reviewed regularly. A relative told us, "We're told by staff of anything on a weekly basis". We saw that monthly summaries recorded details about the activities that people had undertaken, their behaviours and if health appointments had been attended. This meant that staff had up to date information available to them about people's support requirements and were able to offer responsive support based on this. However, we could not see that people, where they could, or their representatives had contributed to a review of their needs. The acting manager said that the recording of people's contribution was something they could improve and would consider our feedback with the manager.

People's support plans contained person-centred information and focused on them as individuals. We saw that their support plans had details about their support requirements and their preferences, for example, for particular food and how staff should support them. We saw that people had 'All about me' documents within their care records. These contained details about their families, what people liked and things that were important to them. For example, we read that one person enjoyed colouring, music and quiet places. We saw that the person was enjoying colouring in a quiet lounge when we visited. This meant that the service was responsive to this person's needs.

Before our inspection we received a concern that there were not enough bathrooms for people to use. We found that there were three bathrooms with a choice of shower or bath for the six people who were currently using the service which was adequate to be responsive to people's preferences.

People were supported to follow their interests and hobbies and chose how to spend their time. On the day of our visit some people were accessing the local day centre and some were shopping for provisions for the home. This had been documented in people's support plans as important to them. People's relatives were satisfied in the activities that their family members were participating in. They told us, "He has enough to do. One thing I would have liked him to do was horse riding because he was good at it and was good for his muscle tone. But he said no. Staff encouraged him too but it's his choice. And once he has made up his mind there is no changing. I know staff did their best". Staff told us about the things that people enjoyed. One staff member said, "We try to go out somewhere nice, a bit special, every month. We go and have a tea

at [name of supermarket] sometimes, or a cafe. A drive out and a nice cup of tea is what some residents like". People told us about a trip to a zoo and smiled when we talked to them about it. This meant that people had access to activities that were based on their likes and interests.

People's relatives knew how to make a complaint should they have needed to. One told us, "I've never had to complain. If I did I would speak to them first, then a social worker". The manager told us that they had not received any complaints in the last 12 months. We saw that the provider's complaints procedure was on display for people and their visitors. However, this was in a written format that some people living at the home would not have been able to understand. The acting manager told us that they would consider how to give this information to people in a way that they understood so that they could make a complaint should they wish to. We also saw that people had been regularly asked about their views on the service through residents meetings that people had attended. When we spoke with staff about how they supported people to make a complaint or raise a concern we were told that they used their communication skills. For example, one staff member said, "It's about looking at a change in behaviour. That may indicate that a person is not happy with something".

Requires Improvement

Is the service well-led?

Our findings

The manager was mainly aware of their responsibilities. For example, we saw that they had submitted a notification and supplied information to the local authority and Care Quality Commission (CQC) where required. This included where a person had died. However, the provider is required to submit a statutory notification where they have been authorised by the local authority to deprive a person of their liberty. We found that this had not occurred for two people using the service. The manager told us that they would submit these after our visit but these had not been received.

The provider had some quality checking processes in place. We saw that some regular audits had occurred. For example, we saw that people's care records were checked every month to make sure they were accurate and up to date. However, these checks did not identify the issues we identified in relation to records not always being complete or containing a consideration of people's mental capacity to make decisions. The provider was also undertaking medicines checks every week. Whilst the list of checks was comprehensive, the checks had not identified that one person's eye drops were stored incorrectly. The provider was not completing regular environmental checks to identify, for example, items that needed repair or upgrading. This meant that people could not be confident that the provider's quality checking systems were sufficient to identify factors that impacted on the care and support received.

The provider had made opportunities available to receive feedback from people and their relatives about the service. We saw that two residents meetings had occurred in the last seven months. These had asked people for suggestions about the menu and activities offered to them. However, we could not see that as a result of these suggestions that action had been taken. The acting manager told us that they would give feedback to people in the next meeting to say what they had done with people's ideas. We also saw that questionnaires had been sent out to people's relatives in the last 12 months. The comments were positive and showed a positive regard for the service. This meant that the provider listened to people.

Staff knew what to do if they had concerns about colleagues working practices. This was because the provider had made available to them a whistleblowing policy that detailed what action staff should take. Staff were able to describe this. One told us, "As long as it did not involve the manager, I would inform them. If the proprietor or manager were involved I could contact the Care Quality Commission". However, we found that the whistleblowing policy did not contain information for staff on who else they could raise their concerns with such as the local authority or CQC. This meant that staff may not have been aware of other organisations that they could contact. We saw that the provider had made a range of policies and procedures available to staff members for them to follow. We asked staff members about some of these and they were able to describe them. In this way staff had been made aware of their responsibilities.

The manager told us that an acting manager was in place who was due to become the manager once fully trained and confident in their role. Relatives spoke highly of the manager and the service. One told us, "Absolutely excellent. I think it's run really well. She has been there since 1997". Another said, "When I come over I just turn up so I see it as it is. I am very happy with it". We saw that two compliments had recently been received by the service and these praised the approach of staff.

Staff told us that they felt supported and could give ideas for how the service could improve. They described how they could also share concerns about people using the service should they have needed to. One staff member told us, "They've been very supportive. If I have any concerns about a resident or staff we can talk about it". We saw that two staff meetings had occurred in the last six months where staff were given updates about the service and it had been documented how the provider was looking to change its philosophy from caring for people to promoting their independence. We also saw that a manager had regularly met with staff to give them feedback on their work. In these ways staff knew what was expected of them.

The provider had a clear vision for the service. This was displayed for people and their visitors in a statement of purpose. This set out what people could expect to receive from the service. For example, we read that people would receive care and support based on their abilities. Staff were able to describe the aims and objectives of the service and we saw them promoting people's independence when we visited.

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 11 HSCA RA Regulations 2014 Need for consent People's consent to their care had not been fully considered and the provider had failed to act in accordance with the Mental Capacity Act 2005. Staff were not familiar with the requirements of the Act. Regulation 11 (1) (3).