Contemplation Care Limited

Deerhurst

Inspection report

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Date of inspection visit:
08 November 2016

Date of publication:
12 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 8 November 2016. The inspection was unannounced.

Deerhurst is a small residential care home which provides care and support for up to three people with a learning disability and autism. The home is located in a quiet cul-de-sac within a local housing estate. People's rooms were located on the first floor which were accessed by stairs. One of the rooms had an ensuite bathroom, the two remaining rooms shared a shower. In addition the home had a lounge and conservatory, a kitchen and separate dining room, a laundry and a staff office. The home had a large garden to the rear of the property and parking to the front. At the time of the inspection there were three people living at the home.

The service had a registered manager. 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 and associated Regulations about how the service is run. The registered manager was also the registered manager of another of the provider's nearby service and split their time equally between the two services.

People told us they felt safe living at Deerhurst and our observations indicated they felt relaxed and comfortable in the presence of their care workers and responded positively when staff approached them or offered them support.

We found, however, that some improvements were needed. People were not always protected from risks associated with the environment. The provider's governance arrangements needed to be more robust to ensure that all of the risks to people were monitored and appropriate action taken when a risk identified.

People's medicines were managed safely and there were appropriate systems in place for obtaining, storing, administering and disposing of medicines.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect.

Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff were supported to provide appropriate care to people because they were trained, supervised and appraised.

Where people were unable to make decisions about their care, staff were guided by the principles of the Mental Capacity Act (MCA) 2005.

Improvements had been made which helped to ensure that people received a nutritious diet.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met.

People appeared relaxed and comfortable in the presence of the staff that were supporting them. Staff had a good knowledge and understanding of people which demonstrated they knew them well.

Meetings were held with people on a weekly basis and were an opportunity for them to make choices about how their care was provided.

People were encouraged to maintain relationships with their family and to make new friends through visiting the providers other homes nearby.

Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person.

Improvements had been made to ensure that people were receiving care that was responsive to their wishes and preferences and allowed them to take part in activities of their choice.

People's support plans were personalised and their preferences and choices were detailed throughout their care records.

People and staff were encouraged to give feedback about the service and this was used to drive improvements. Complaints policies and procedures were in place and were available in easy read formats.

The registered manager demonstrated a good understanding of all aspects of the home and the needs of people living there. Staff were positive about the leadership of the service. They felt listened to, respected and supported in their roles.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 always protected from risks associated with the environment.

People's medicines were managed safely and there were appropriate systems in place for obtaining, storing, administering and disposing of medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff were supported to provide appropriate care to people because they were trained, supervised and appraised. Where people were unable to make decisions about their care, staff were guided by the principles of the Mental Capacity Act (MCA) 2005.

Improvements had been made which helped to ensure that people received a nutritious diet.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met.

Is the service caring?

Good

The service was caring.

People appeared relaxed and comfortable in the presence of the staff that were supporting them. The staff had a good knowledge and understanding of people which demonstrated they knew them well.

Meetings were held with people on a weekly basis and were an opportunity for them to make choices about how their care was provided.

Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person.

Is the service responsive?

Good

The service was responsive.

Improvements had been made to ensure that people were receiving care that was responsive to their wishes and preferences and allowed them to take part in activities of their choice.

People's support plans were personalised and their preferences and choices were detailed throughout their care records.

People and staff were encouraged to give feedback about the service and this was used to drive improvements. Complaints policies and procedures were in place and were available in easy read formats.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's governance arrangements still needed to be more robust to ensure that all of the risks to people were monitored and appropriate action taken when a risk identified.

The registered manager demonstrated a good understanding of all aspects of the home and the needs of people living there. Staff were positive about the leadership of the service. They felt listened to, respected and supported in their roles.

Deerhurst

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.

The inspection took place on the 8 November 2016 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

People were able to tell us a little about their experience of living at Deerhurst, but we also spent time observing interactions between people and the staff supporting them. During the inspection we spoke with two people. We also spoke with two relatives, the operations manager, registered manager, and two staff. We reviewed the care records of one person in detail and specific aspects of one other person's care plan. We viewed the medicine administration records for all three people. Other records relating the management of the service such as audits, meeting minutes and staff rotas were also viewed.

The last inspection of this service was in July 2015 during which we found that the provider was not meeting the required standards in relation to staffing and their quality monitoring systems. This inspection checked whether the provider had made the planned improvements described in their action plan.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Deerhurst and our observations indicated they felt relaxed and comfortable in the presence of their care workers and responded positively when staff approached them or offered them support.

We found, however, that some improvements were needed. People were not always protected from risks associated with the environment. A number of windows on the first floor did not have window restrictors in place. The water being discharged from some of the hand basins used by people, when unsupervised, was in excess of safe limits as recommended by the Health and Safety Executive. A cupboard containing substances that are harmful to people's health was not locked or secured.

The failure to assess and plan for these risks affecting people's safety is a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the provider has identified a number of measures they are taking to address all of the above areas. These will be completed within clear timescales.

Other risks associated with the environment were well managed. Tests took place to ensure people were protected against the risks associated with legionella. Person centred records were available which detailed the assistance each person required for safe evacuation of the home. The fire risk assessment and fire equipment tests were up to date and staff were trained in fire safety. There were current certificates for gas and electrical safety. The provider had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people.

People had risk assessments in relation to a range of areas such as epilepsy, accessing the community, the risk of absconding and the risk of financial abuse. Staff were informed about each person's risks and were able to describe the strategies in place to manage these. For example, staff described the interventions they used to help calm or de-escalate behaviours displayed by one person. We did notice however, that one person who was risk of choking did not have a choking risk assessment and their eating and drinking plan did not reflect their known dietary risks or relevant guidance from a speech and language therapist. Whilst the staff we spoke with were informed about this person's needs, agency staff were used within the service on a regular basis and the lack of guidance increased the risk of the person receiving inappropriate care. Since the inspection, the provider has confirmed that action had been taken to re-write the person's eating and drinking care plan.

Staff were able to share with us examples of positive risk taking. For example, we were told how staff had identified how one person preferred to walk behind staff when out in the community. There had been a concern about this as the person did not understand the risks presented by traffic and roads. However, in order to try and meet the person's wishes, staff had looked at routes where this might be possible, whilst minimising any risks, such as taking walks through parks or on the beach.

People's medicines were managed safely and there were appropriate systems in place for obtaining, storing, administering and disposing of medicines. Staff who administered medicines had completed training and underwent annual competency assessments. Medicines were kept safely in locked cabinets. The temperature of the areas used for storing medicines was being monitored daily and records showed that the medicines were being stored within recommended temperatures. There were protocols in place for the use of 'as required' or PRN medicines. These included information about the strength of the drug and the maximum dose to be given in 24 hours. We did note that some of these protocols could provide more detailed information about the signs or behaviours which might indicate that the person was in pain. This is important as some of the people using the service would not have been able to verbally communicate this. Since the inspection, the provider has confirmed that a more detailed protocol has been put in place. The medicines administration records (MARs) viewed contained all of the required information and did not have any gaps or omissions which provided reassurances that people were receiving their medicines as prescribed.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The organisation had appropriate policies and procedures and the local multi-agency procedures for reporting abuse were available. The registered manager told us that team meetings were used to reflect upon safeguarding case studies and annual appraisals were used to ensure that staff understood their responsibilities to share any concerns about people's welfare. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff told us they were aware of how to report concerns about poor practice which is often known as whistleblowing. They were also aware of other organisations with which they could share concerns about abuse or poor practice and information about the whistleblowing policy was displayed within the office.

There were sufficient staff on duty to meet people's needs. During the day there were either one or two staff on duty to care for the three people. The second care worker when rostered often worked 9-3pm or sometimes 9-6pm. At night there was one waking night staff. Each shift had staff rostered who were drivers, trained in the administration of medicines and in emergency first aid. The registered manager told us the staffing levels were determined by people's individual needs assessments which were undertaken by the commissioners of their placement within the home. However, they advised that at times they took the decision to increase staffing levels to ensure people had the support they needed to undertake specific activities. All of the staff we spoke with told us the staffing levels were adequate. One staff member said, "I've never had a problem with the staffing, we plan for weekend events and get extra staff in". Our observations during the inspection indicated that the staffing levels enabled people's needs to be met in a safe manner.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. Staff were required to undertake two interviews which were competency based and sought to gain an understanding of how caring the person was and how they might respond to safeguarding concerns. These measures helped to ensure that only suitable staff were employed to support people.

Good

Is the service effective?

Our findings

People were supported by staff that had a good knowledge of their needs and during our inspection we observed that staff delivered care effectively and to an appropriate standard. We observed staff working in a professional manner and communicating with people effectively according to their needs. A relative told us that Deerhurst was "The best place [their family member] can be".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The need to act in accordance with people's consent and choices was clearly referenced throughout their support plans. For example, one care plan stated, 'Give choice of cereals, fruit and toast, offer scrambled egg'. The plan also described how the person was able to choose their own clothes. Where people used specific communication techniques to indicate their choices, these were described. For example, one care plan stated, 'when I want something, I will take your hand and lead you'. We saw this person expressing their choices and wishes in this manner and staff responding positively.

Where people were unable to make decisions about their care, staff were guided by the principles of the Mental Capacity Act (MCA) 2005. Staff had completed decision specific capacity assessment regarding people's ability to consent to living within the service and having support to manage their finances. Detailed records had been made of which options had been agreed to be in the person's best interests. Further assessments were planned to determine whether people had the mental capacity to consent to staff administering their medicines and other key aspects of their care and support. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home.

New staff received a robust 12 week induction which was mapped to nationally recognised standards. During their induction staff received regular supervision to ensure they understood their role and responsibilities. The provider employed a training & development manager who was responsible for the planning and delivery of training which included, moving and handling, person centred care, first aid, safeguarding people and the MCA 2005, fire safety, infection control, health and safety and moving and handling. All staff had their competency to administer medicines, and undertake moving and handling tasks, assessed on an annual basis. A training plan was on display in the office and showed the dates of future training which staff were encouraged to sign up for. Planned future training included a nationally recognised distance learning course in autism and training in how to use positive strategies to de-escalate behaviour which might challenge others. Staff were positive about the training available and told us it helped them to perform their role effectively.

Support for staff was achieved through individual supervision sessions and an annual appraisal.

Supervisions included the opportunity for staff to reflect on their practice. A 'Safe to Practice' model was used which meant that each session, focused on a different area of practice helping to ensure that staff were able to demonstrate they had the skills and knowledge to carry out their role effectively. Areas covered included safeguarding, infection control and helping people to eat and drink.

Our last inspection made a recommendation that the provider review the menus in line with national guidance to ensure people were receiving a nutritious diet. This inspection found that improvements had been made. People were involved in decisions about what they ate and staff told us that each week, they all sat down together and planned the weekly menu. Pictures of a large range of meals were available to help people make choices about what they would like on the menu each week. A list was also available of people's likes and dislikes. Staff took the lead in cooking meals but said that they encouraged people to get involved as they were able to do so but this was on a limited basis. On the day of our inspection, people enjoyed a freshly cooked tuna pasta bake for supper. People seemed to enjoy this with very little being left uneaten. A staff member told us they were having fresh fruit salad for dessert. Other meals planned for the week of our inspection included, braised lamb, baby corn and mangetout. A member of staff said, "The menu has changed drastically, they [people] have nothing from a jar any more, they have lots of fruit, vegetables and salad…..everything, I cook, I would eat, such as ratatouille". The registered manager told us how they cooked roast dinners sometimes with as many as five different vegetables. People had access to plate guards which enabled them to remain as independent as possible with eating their meals.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met. This included GP's, dentists and opticians. For example, staff had consulted with one person's doctor when they had noticed that they were showing signs of being pale and lethargic. The doctor diagnosed an infection that required antibiotics. People were also supported to attend for screening programmes and for reviews of chronic health conditions such as diabetes. People's care records contained information about their medical history and records were maintained of the outcome of medical appointments and visits from the GP or other healthcare professionals. The provider was working with specialist hospital learning disability nurses to develop a hospital passport for each person. Hospital passports are used to share key information with medical staff about the person's needs, their communication methods and behaviours in the case of admission to hospital.

In general, the layout and design of the building was suitable for people's needs. People's room were large and decorated with their personal possessions and provided a space for them to have privacy. The communal areas were spacious and enabled people to spend time together if they wished watching TV for example. We did note that some areas of the environment needed some attention and some of the fixtures and fittings replacing and cleaning. For example, the microwave was rusting badly; this would make the oven difficult to clean effectively. Under the kitchen sink was dirty and the plinth broken. The operations manager told us action would be taken to address these issues.

Good

Is the service caring?

Our findings

People were able to tell us a little about their experience of living at Deerhurst, but we also spent time observing interactions between people and the staff supporting them to see whether they were treated with kindness and their dignity and privacy was respected. One person told us they were "Happy". They showed us their room which they clearly proud of. They told us their favourite thing was their collection of DVD's. Another person told us, their favourite thing about living at Deerhurst was a specific staff member. We asked them if there was anything they didn't like about living at the home, they said "No". Our observations indicated that staff did show people kindness, patience and respect. The atmosphere was positive and it was clear that the staff we met had developed a good relationship with each person and that they in turn were comfortable and relaxed with the staff supporting them. One person, who was living with sensory problems clearly valued being able to seek touch from staff. This was provided in an appropriate but responsive manner. A staff member told us, "Yes the staff are kind and caring, if I ever had an issue, I would take it straight to [the registered manager]".

Staff showed they had a good knowledge and understanding of the people they were supporting. Staff were able to give us detailed examples of people's likes and dislikes which demonstrated that they knew them well. We were given examples of the types of food people liked to eat and what activities they enjoyed as well as their preferred daily routines. A relative told us staff were "Completely in tune with [their family member]…he is happy, they understand him".

The registered manager and staff told us that the people were involved in planning their care and support as much as possible. Meetings were held with people on a weekly basis and were an opportunity for them to make choices as able about their meals for the week and the activities they wanted to take part in. A care worker told us how they had spent time with one person who had sensory needs, going through their care plan, updating it and then re-recording the audio version of the care plan in line with the person's wishes.

People were encouraged to maintain relationships with their family and to make new friends through visiting the providers other homes nearby. We were told that relatives were welcomed at the home and had been invited to join their family members for a Christmas party. People were also supported to visit their family in their own home. One person told us he was going on Sunday to see his parents. Where people did not have close family or visitors we were told that referrals were made to a local advocacy service to support decision making. For example, one person had been referred for advocacy support with developing an end of life care plan. This helped to ensure people were able as far as possible, to express their choices and wishes and to influence how their care was provided.

Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person. They told us how they remained observant for people not closing the bathroom door when using the toilet or leaving the bathroom not fully dressed and therefore compromising their dignity. They said, "I remind them quickly, I look at it as if it was me, how I would want things done". Staff told us they were careful to ensure people's doors were closed when providing personal care and privacy screening was in place on certain windows. The home had a dignity champion whose role was to

model dignity in care and highlight where practice could be improved and dignity audit had been undertaken in January 2016.

Good

Is the service responsive?

Our findings

At our inspection in July 2015, we found that the service was not meeting the essential standards regarding staffing. This was because the staffing levels at weekends and evenings, did not allow for staff to be responsive to people's individual wishes or to any spontaneous requests they might make to take part in activities. This inspection found that the provider had taken reasonable steps to address this and to ensure that overall people were receiving care that was responsive to their wishes and preferences and met their needs.

The current staffing levels were based upon the assessed needs of people which were determined by the commissioners of their care. The provider explained that following a series of meetings, the commissioners did not feel that additional staff should be made available at weekends and evenings 'just in case' people wanted to go out or attend an activity. However, to help ensure the service was as responsive as possible to people's wishes, on occasion, the provider was providing additional staffing to facilitate a number of outings or trips. For example, in November 2016, additional staff had been provided to accompany people to a theatre trip. In October, a weekend day trip had been organised to Dorchester. Additional staff had been provided for this. Records showed that, throughout the year, additional staff had also been scheduled to enable people to attend activities such as bowling, the cinema, picnics and a barn dance. A staff member told us, "Nine out of ten choices can be met….if we are going to a panto in the evening, the 9-3 shift will start later…it's about explaining and compromising". Staff told us how if two people wanted to go out but the third did not, the registered manager would on occasion come in on their day off to support that person. Another staff member said, "They [people] do a lot more than they used to, they go to cinema, baking, crafts, the other homes visits, we are having a disco party soon for a birthday, in the summer we go the beach… we get them out as much as possible". A relative told us their family member had "Lots of entertainment".

The above one off activities were in addition to people's planned weekly activities. For example, one person attended a local day service one day a week, people took part in bingo held at another of the provider's nearby home on a weekly basis and a friendship group one morning a week. Links with the local community were maintained through regular drives out in the mini bus for walks or a pub lunch. People attended coffee mornings run by another of the provider's care service's which the members of the local community attended also. Some time each week was put aside for people to be involved in household chores, for example cleaning their rooms, although we were told they were not always keen on this. The registered manager told us that it was an on-going challenge to source activities that people enjoyed, were affordable and available to be supported within the hours funded by the commissioners. However, the operations manager said, ""Everything, they [people] enjoy, we look to fulfil. We do believe they have opportunities….we try to use the hours available for the benefit of all".

People's support plans were personalised and their preferences and choices were detailed throughout their care records. This supported staff to deliver responsive care. Each person had an easy read version of their support plan which contained some information about them as a person, what they wanted their life to be like and what support they needed. The plans were available in a format that the person could understand. For example, one person had a pictorial care plan and another, an audio care plan. The plans described

what was important to the person. For example, one person's plan explained that they liked to have regular walks and periods where they could just relax. In addition to the easy read plans, each person had a range of more detailed support plans for staff which covered areas such personal care, medicines and personal safety. These plans included information about how people communicated and what aspects of their behaviour might mean. For example, one plan noted that when the person was happy, they would sing loudly and smile, and when tired, they would like to relax on the sofa. One person had a positive behaviour support plan which included detailed information about how staff should interact with them when displaying behaviour which might challenge others. This helped to ensure staff understood the needs of the people they supported and enabled them to care for them in a personalised manner.

Staff maintained daily records which were mostly detailed and noted how the person had been, what they had eaten and what activities they had been involved in. This helped to ensure that staff were able to effectively monitor aspects of the care and support people received. Care records were reviewed on a three monthly basis to help ensure they remained accurate and reflected people's current needs. A care worker said, "If things change, we tell [the registered manager] she updates it, its very responsive". At our last inspection, we made a recommendation that the provider ask commissioners to undertake more regular reviews of people's care. The registered manager was able to confirm during this inspection that all three people had received a review of their placement and assessed needs. This helped to ensure the service remained appropriate for their needs.

People and staff were encouraged to give feedback about the service and this was used to drive improvements. For example, they had been asked to give 'Three Question' feedback about the activities and trips they had been part of. The feedback was positive with one person noting 'I enjoyed it, it made me laugh'. The feedback gathered as part of the staff questionnaires was also positive.

Complaints policies and procedures were in place and were displayed in communal areas in easy read formats. There were arrangements in place to record complaints that had been raised and what action had been taken about resolving the issues of concern. A relative told us they felt able to speak with the registered manager about any concerns and had in the past been "Happy with the response".

Requires Improvement

Is the service well-led?

Our findings

People did not make any specific comments about the leadership of the home, but our observations indicated that they had a good relationship with the registered manager, were happy spending time in their company and appeared to have a genuine rapport with them. Staff were positive about the leadership of the service, their comments included, "I feel supported, if you need the on call, someone will come". Another staff member told us the registered manager was "The best manager I have had anywhere, concerns are looked into and resolved". Another said, "They are the best manager….they listen, are approachable, easy going….they may advise but are not opinionated….you are made to feel like a person not a robot".

At our inspection in July 2015, we found that the provider did not have effective systems in place to identify where quality and safety were at risk of being compromised. Specifically, audits relating to the safety of medicines were not sufficiently robust. This inspection found that improvements had been made in relation to checking the safety of medicines and we did not find any new concerns regarding this. However, improvements were still needed to some aspects of the provider's governance arrangements. For example, the provider's checks had not identified the concerns regarding the lack of window restrictors. In some cases where issues or concerns had already been highlighted, it was not clear what action was being taking to address these. For example, the registered manager had been reporting since June 2016 that the water being discharged from one of the hand wash basins used by people was too hot.

Other aspects of the provider's governance arrangements worked effectively. The provider had a service quality manager who undertook regular visits to the service to check on the quality of care being provided. Reports were produced as a result of these visits and if any areas for improvement were identified, the registered manager was provided with an action plan which detailed the actions needed to address the shortfall. We were able to see evidence that these actions had been completed, for example, new garden furniture had been purchased

Systems in place to monitor and investigate incidents and accidents were not always being used effectively. For example, in one person's care plan there was a body map recording that staff had noted an unexplained bruise. The registered manager told us that investigations had been undertaken to identify the cause of the bruise but these had not been documented. An incident form had also not been completed. This was not in line with the provider's policies and procedures. The provider has told us that in response to this issue, all of the managers in the whole group have been reminded of the importance of investigating and clearly documenting such incidents. This demonstrated the provider's commitment to ensuring that where areas for improvement were identified, this was used as an opportunity for driving improvements. Biannual managers meetings were held and also used as a forum for sharing skills and knowledge and organisational learning. For example, the meeting in August 2016 had explored inspection methodology, staff training and the results from surveys undertaken with people using the service.

The registered manager demonstrated a good understanding of all aspects of the home and the needs of people living there. They understood the challenges faced by the service which included on-going recruitment and maintaining the quality of activities despite potential cuts in the available funding. The

registered manager had created an open and transparent culture with the staff team. Staff meetings were held on a regular basis. Issues discussed included staffing matters, and updates to people's needs and risks. The meetings were used to check the skills and knowledge of staff in key areas such as safeguarding and the Mental Capacity Act 2005. The meeting minutes showed that staff were able to discuss any concerns they might have and were able to contribute to the development of the service and people's support. Staff told us they felt confident going to the registered manager with any concerns or ideas and they felt that they would listen and take action. All of the staff we spoke with were committed to providing good person centred care and support and were proud of the job they did. Staff clearly enjoyed their work and told us morale amongst the staff team was good. One staff member said, "The staff get along, no-one is ever afraid to say anything….everyone is treated as equals, there is no special treatment, they [the registered manager] are fair".

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess and plan for all of the risks affecting people's safety. Regulation 12 (2) (b).