Networking Care Partnerships (South West) Limited

1-4 Windsor Drive

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

1-4 Windsor Drive is made up of four bungalows. They are registered together to provide personal care and support for up to 12 people with a learning disability. Each bungalow provides accommodation for three people. At the time of the inspection the service was supporting 11 people.

The inspection took place on 19 and 21 December 2016 and was unannounced. The service was previously inspected in June 2014 and was found to meet the regulations inspected at that time.

The service had 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.

Prior to the inspection we had received information about the welfare of one person supported by the service. Concerns were raised with us that this person's complex care needs were not being met. We reviewed this person's care. We saw the service was working with staff from the local authority to ensure this person was safe. However, we did find that improvements were required in the number of staff available to respond promptly and consistently people's support needs.

Staffing levels did not promote opportunity or choice for people to engage with staff or participate in activities outside of the home. In addition, while some people's care and support needs were clearly identified in their care plans and risks to their health and safety were being well managed, this was not the case for everyone. Systems in place to assess quality and risk had not been effective in identifying these issues.

The registered manager and staff told us they felt there were insufficient staff available to meet people's care needs. Staff were identified to work in each of the bungalows but at times there was insufficient staff in the bungalows to support people with their personal care, such as going to the toilet. Staff told us they asked staff from one of the other bungalows to help them at these times. Staff told us that they were anxious there was not always enough staff available to support people in the way they wished to be supported. Relatives told us they felt there was not enough opportunity for people to go out of the service as there was not enough staff on duty. Following the inspection, the registered manager confirmed that staffing levels had been increased.

Not all care plans provided staff with accurate guidance about people's current care needs and how risks to their health and safety should be managed. Two of the three care plans we looked at provided staff with clear guidance about people's care and their preferences. However, the third care plan did not accurately reflect the person's care needs. Staff were not guided about how to support the person with their personal hygiene, how to encourage the person to become involved in activities or how to support them at times of anxiety and distress. Information held in the care plans stated whether people had the capacity to consent

to the support identified in these plans. However, there were no records of formal capacity assessments having been undertaken for those who staff thought lacked capacity.

During our observations we saw kind and friendly interactions between staff and some people. However, we observed staff favouring those people who were able to communicate with them and those with limited communication abilities received less attention from staff. While staff were not being outwardly unkind to people, they ignored people who, due to their disabilities, were not able to seek staff company and interaction.

Relatives and advocates told us they found the staff caring and kind. Staff were described as "excellent" and "absolutely amazing". Staff talked of people fondly when they told us about people's support needs. One member of staff said, "When he smiles, it fills my heart."

Staff received a variety of training to ensure they understood people's care and support needs. This training included safeguarding adults from abuse. Risks to people's well-being due to poor mobility or medical conditions such as epilepsy were well recorded. Staff were provided with clear information about how to support people safety and minimise these risks. Specialist advice was sought when appropriate from healthcare professionals such as the community nursing team, occupational therapists and medical consultants at the local hospital. The community nurses we spoke with were confident people's healthcare care needs were being well met. People's medicines were managed safely and people received their medicines as prescribed.

Although staff, relatives and advocates had some concerns over the staffing arrangements at the service they told us they felt the service was well managed. One relative described the service as "excellent in the way it's run" and an advocate said of the registered manager, "I really rate [name], she has standards." Relatives and advocates told us they had no complaints and felt they could talk to the registered manager if they did. Staff told us they enjoyed working at the service and were well supported. They said the registered manager was approachable and always had time for them. One staff member said, "It's a nice place to work, I like it here".

We made a recommendation and identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 where improvements were required.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels did not ensure people received responsive and consistent care.

Inadequately detailed plans did not support staff to mitigate the risks for some people in relation to their health, safety and well-being.

People received their medicines as prescribed. The systems in place for the management of medicines were safe and protected people who lived in the service.

People were protected from the risk of abuse as staff understood the signs of abuse and how to report concerns.

Is the service effective?

Good

The service was effective.

People's rights were respected. Staff had a clear understanding of the Mental Capacity Act 2005; however some documentation in relation to people's capacity to consent to care required further clarity.

Staff were provided with training and understood people's individual care needs. People saw health care professionals promptly when needed.

People were supported to have enough to eat and drink and staff were aware of their preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always demonstrate a respectful relationship with all of the people living at the service.

Staff knew people well and spoke fondly about people.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all care plans described people's current needs or guide staff with how to support people. Care and support needs were not always being met in people's preferred manner.

Opportunities for meaningful engagement in activities that interested people, both in and out of the service, were limited.

Relatives and advocates were encouraged to share their views and raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to assess and monitor the quality of the care provided to people. However, where shortfalls had been identified, action had not been taken to improve the service.

People and relatives spoke highly of the registered manager and confirmed they were approachable.

1-4 Windsor Drive

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 21 December 2016 and was unannounced. The inspection was carried out by one adult social care inspector. Prior to the inspection we reviewed the information we had about the service, including safeguarding information and notifications of events the service is required by law to send us. 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.

Due to people living with a learning disability and having limited verbal and non-verbal communication abilities mostly people were unable to talk to us about their experience of living at the service. During our inspection it was not appropriate to conduct a short observational framework for inspection (SOFI) due to the layout of the service over four bungalows. SOFI is a specific way of observing care to help us understand the experience of people who are unable to talk to us. However, we did use the principles of SOFI when making observations of how staff supported people.

We looked around the bungalows and spent time with people in all four lounge rooms. We observed how staff interacted with people throughout the inspection. We met and spoke with nine of the 11 people being supported by the service. We also spoke with six relatives and advocates, two health care professionals, a visiting aromatherapist, seven members of staff, the registered manager and the provider's area manager.

We looked at the way in which the service supported people with their medicines. We looked in detail at the care provided to three people, as well as the recruitment files for three staff members and other records relating to the running of the service such as staff training and quality monitoring.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we had received information about the welfare of one person living in the service. Concerns were raised with us that this person's complex care needs were not being met. We reviewed this person's care. We saw the service was working with staff from the local authority to ensure this person was safe. However, we did find that improvements were required in the number of staff available to respond promptly and consistently people's support needs.

The registered manager told us staffing levels were arranged to meet the needs of those living in each bungalow. There were three people living in the first bungalow and they were supported by two members of care staff, one of whom was exclusively on duty to support one person. The three people living in the second bungalow were supported by one member of staff. The five people living in the third and fourth bungalows, which were adjoining, were supported by two or three members of staff dependent upon the activities planned for that day. The registered manager and deputy manager were on duty during the day and staff said both provided care and support to people. During the night there were three waking and one sleeping-in members of staff on duty. In addition to providing care to people, staff confirmed they did the cooking and cleaning in the service as well.

The registered manager and staff told us they felt this level of staffing was not sufficient to meet the needs of those currently receiving support. For example, five people required the assistance of two members of staff with their mobility needs and to assist them with their personal hygiene. This included one person in the second bungalow, where only one member of staff was available. Staff in this bungalow told us they had to phone the staff in the third and fourth bungalows when they needed help to support this person with their personal care.

Relatives and advocates told us they felt there was insufficient staff available, although their concerns related to people having the opportunity to go out of the service rather than concerns over their safety. One relative also told us they had seen one member of staff trying to assist three people to eat their meal at the same time as no other staff were available. Another relative said, "The staff are always changing."

Failure to provide sufficient staff to ensure people's needs can be met in a timely and consistent manner and in the way people prefer is a breach of Regulation 18 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

In addition, one person had been assessed as requiring one-to-one staffing but this was not being provided at the time of the inspection. Staff told us they felt there was insufficient staff to support this person safely and in the manner they preferred with their personal care. They said this person suffered high levels of anxiety which could lead to potentially aggressive behaviour. One member of staff said they were "walking on eggshells" to try to prevent this person becoming distressed and they said staff were wary of interacting with them. The registered manager had made contact with the commissioning authority on a number of occasions in order to increase this person's contacted staffing hours. However, although the authority had agreed this was necessary, they had yet to approve the increase. Following the inspection, the registered

manager confirmed that staffing levels within the home had increased and this had resulted in staff being better able to support this person.

All those currently receiving support had a learning disability and varying communication abilities. Some people were able to tell us they were happy living at the service, while others were unable to verbalise their views. As people could not tell us in detail about their care, we spent time observing people and spoke with staff to ascertain if people were safe. During our observations people appeared to be relaxed and looked happy when staff approached them and spoke with them. People were happy for staff to take their hands; they made eye contact and smiled at the staff. This indicated people felt safe and comfortable in the service. Relatives, advocates and health care professionals told us they were confident with the care people were receiving and had no concerns over their welfare and safety. One relative said, "With the care I've seen, I have no concerns."

Staff had received training in safeguarding people and knew what to do if they suspected people were at risk of abuse. The provider had safeguarding policies and procedures in place. The contact details for reporting any issues of concern directly to the local authority's safeguarding team were on display on a staff notice board. Staff and relatives were confident the registered manager would take action to protect people should they identify someone was at risk. In the Provider Information Return (PIR) the registered manager said the service had a keyworker system. This ensured each person had a named member of staff to review their support needs and liaise with their families. They told us the keyworkers had a close supportive relationship with people and as such would be able to assess and recognise changes in people's well-being.

All the people receiving support required assistance from staff to take their medicines. Staff were knowledgeable about how people preferred to take their medicines and had responded well to one person's changing needs. This had resulted in the person being more accepting of taking their medicines which had resulted in an improvement in their well-being. Records of medicines administered confirmed people had received their medicines as they had been prescribed by their doctor. The registered manager confirmed medicines were only administered by staff who had received training in how to do this safely. Each person's medicines were securely stored separately. Medicines administration records (MAR) were competed at the time medicines were administered and those we looked at had been fully completed with no gaps in the recordings. For those people who required medicines with variable doses we saw this information was clearly provided for staff. Special precautions, such as not being able to take particular medicines, were highlighted in people's MARs and care plans.

Risks to people's health, for example in relation to medical conditions such as epilepsy were well managed. Staff were guided about how to respond when people had an epileptic seizure and when to call an ambulance. A number of people had restricted mobility and were at risk from developing pressure ulcers. Equipment necessary to reduce this risk and to support staff with their care, such as air mattresses, hoists and height adjustable beds, was provided. People's care plans guided staff about how to use this equipment safely. For people at risk of choking when eating and drinking, assessments and guidance had been sought from the NHS Trust's Speech and Language Therapists. People's care plans described how people's food and drinks should be prepared to reduce risks, and we saw these meals and drinks being provided. Staff were also instructed not to leave people unsupervised when they were eating. Staff were knowledgeable about how to support people safely. Should an accident occur the registered manager reviewed these to look for any trends that might indicate a change in people's needs and to ensure risks to people were minimised. The information was also sent to the provider's head office.

Recruitment practices ensured, as far as possible, that only suitable staff were employed at the service. Staff files showed the relevant checks had been completed to ensure staff employed were suitable to work with

people who were vulnerable due to their circumstances. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained as well as full employment histories and this protected people from the risks associated with employing unsuitable staff. The registered manager confirmed that some of the people living at the service were involved in the recruitment of staff and met with prospective new staff prior to their interviews. They said people were asked for their views about prospective staff prior to making a decision to employ them.

We looked around the service and at the equipment used to assist people. The service had adapted baths to enable people with restricted mobility to use these safely. There were systems in place to make sure equipment was maintained and serviced as required. Staff used protective clothing such as aprons and gloves to reduce the risk of cross infection when necessary. There was a file containing certificates to show gas and electrical safety tests were carried out at the correct intervals. Personal emergency evacuation plans were in place which gave staff clear directions on how to safely evacuate people from the building should the need arise, such as a fire.

Good

Is the service effective?

Our findings

Many of the staff had worked at the service for several years and knew people well. They were familiar with their care needs and their preferences about how they wished to be supported.

A training programme ensured staff received the training necessary for their role. Staff told us they received "lots of training" which included face-to-face training and eLearning. Training included topics relating to people's specific care needs, such as supporting people with epilepsy, autism and mental health needs, as well as health and safety topics, such as medicines administration, safe moving and transferring and food hygiene. Certificates for this training were seen in staff files. The registered manager told us new staff completed the service's induction programme, and for those who were employed with no previous care experience, they would also undertake the care certificate. The care certificate is an identified set of standards used by the care industry to ensure staff provide compassionate, safe and high quality care and support. Staff training needs were regularly reviewed and discussed with them during supervisions and appraisals.

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. We saw that capacity assessments had been undertaken for some people regarding major decisions affecting their well-being. For example, an assessment and best interest decision had been made for one person about whether they should move from one bungalow to another. Where staff felt people lacked capacity to consent to the care activities and support identified in their care plans, a statement in the plan identified this but there was no evidence a formal capacity assessment had been undertaken.

We recommended that the service seeks guidance about formally assessing people's capacity to consent to activities carried out in connection with their care needs.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the 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 were being met. The registered manager confirmed that applications had been made on behalf of all those receiving support as it was recognised they were under constant supervision and would be unsafe to leave the service unsupervised. Due to the high volume of applications received by the local authority only one had been authorised at the time of the inspection.

Records showed staff sought specialist advice from healthcare professionals when required. For example, where people required equipment to support their independence such as handrails in the bathroom, staff had sought advice from an occupational therapist about where these should be placed and whether these were safe for people to use. The registered manager confirmed, and records showed, people saw their GP or

attended hospital appointments regularly for general reviews as well as when staff were concerned over their health. Care plans guided staff about what signs look for which might indicate changes to people's health. For example, one person was at risk of urinary tract infections and staff were guided about providing them with increased fluids and when to contact their GP. For another person with a chronic health condition, staff were given very clear guidance about what emergency action to take should they show signs of deterioration. During the inspection we had the opportunity to speak with two community nurses. Both said they had no concerns about how the care and support was provided at the service. They said staff knew people well and were prompt to contact them for advice if they were worried over people's heath. People's care files held records of annual health checks and 'Hospital Passports' for those people who required specialist treatment. These provided hospital staff with important information about people's care needs.

People's food preferences were known to staff and people were supported to follow a healthy balanced diet. Care plans described how staff should support people to eat as independently as possible. For example, one person could eat the majority of their meal without support but when they became tired, staff were guided about how to provide support. For people who were at risk of not eating enough to maintain their health, staff were knowledgeable about how to encourage people to eat and drink, for example by providing them with their preferred foods. People's food and fluid intake was recorded and staff reviewed these daily to assess whether people were eating and drinking enough. We saw these records in people's care files. Care plans guided staff about what action to take if people weren't eating well. Nutritional supplements had been prescribed for some people and we saw these were given as directed. People were also weighed monthly to ensure they maintained a stable weight. Records showed one person at risk of not eating enough had gained weight over the past five months. An advocate for one person told us staff were supporting them very well with their specialist dietary requirements.

Requires Improvement

Is the service caring?

Our findings

All those living at the service had limited verbal communication. Some people were able to respond to questions about whether they were happy, while others were not. We spent time observing people in all four lounge rooms. We saw people smiling and they appeared happy to spend time with staff.

During our observations we saw kind and friendly interactions between staff and some of the people being supported. However, we saw staff spent more time with those people who were able to verbally communicate with them than with those who had little or no verbal communication. For example, during time spent in one of the lounge rooms, we saw staff speaking frequently to one person and only approaching the other two people in the room once in the 90 minutes of our observation. We saw staff show one person an item of food and ask them if they would like this for their meal. They did not show this to the other two people or ask them whether they would like this for their meal. While staff were not being outwardly unkind to people, they ignored people who, due to their disabilities, were not able to seek staff company and interaction. As such staff failed to demonstrate a respectful relationship with all of the people receiving support. We discussed our observations with the registered manager. They confirmed they would discuss our findings with the staff and ask them to reflect on how they support and interact with all of the people in the service.

Failure to ensure each person is treated with dignity and respect is a breach of Regulation 10 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Relatives and advocates told us they found the staff caring and kind. Staff were described as "excellent" and "absolutely amazing." One relative said the staff supported people "patiently and with so much care". An advocate said they "couldn't wish for better" and "they [staff] go the extra mile" when they described to us the care and support they had witnessed from staff. However, one relative said that at times they had heard staff being rude to people.

Staff talked of people fondly when they told us about people's support needs. One member of staff said, "When he smiles, it fills my heart" and another said, "He loves to have a laugh and he teases us." We saw acts of kindness from staff. For example, one member of staff gave a person a present of a snowman teddy. They said this person was very fond of teddy bears and they knew they would like this one.

Relatives and advocates told us people were supported to maintain friendships and relationships. Staff supported people to keep in touch those who were important to them. People had made friends through various social activities and staff recognised the importance of ensuring people could attend these events to meet their friends. We saw that one person was supported to use technology to support their communication and to contact friends and family by email. Staff said visitors were welcome at any time and relatives and advocates confirmed this. One relative said, "The staff are very good and make me welcome."

Not everyone was able to be actively involved in planning their care. However, staff knew people well and when planning care, took into account what they knew about the person and their preferences. Relatives

were involved in planning care when they wished to be and those we spoke with confirmed they were fully consulted about their relation's care.

The service was able to support people should their health decline and they require 'end of life' care. The registered manager said they were supported by the community nurses to ensure people's care needs could be met.

Requires Improvement

Is the service responsive?

Our findings

Relatives, advocates and health and social care professionals told us they felt people received care and support that was responsive to their needs. One relative told us they were "really, really pleased" with the care and support their relation received. Another relative said, "I've never known her so happy. They are caring for her beautifully and wonderfully well. It's service for her." An advocate for one person told us they had seen an improvement in the person's well-being since moving to the service.

However, we found there were areas of care and support that required improvement.

Each person had a care plan which gave staff important information about their individual needs. We looked at three care plans for people with varying care needs. Two of the three care plans we looked at contained detailed information about people's support needs and how staff should provide assistance in a consistent manner that reflected people's preferences. Staff were provided with step by step guidance about how people liked to be assisted and how they should use equipment safely.

One care plan was disjointed and did not reflect the person's current care needs. It did not guide staff how to support them at times when they were anxious or distressed and could potentially display behaviours that might place others at harm. It was necessary to review several documents to gain a picture of this person's support needs and some of this information was contradictory. For example, the care plan stated this person had difficulty in expressing themselves but went on to say they were able to communicate their emotions. It stated the person "will choose" when they would accept assistance with personal care and that they had periods of self-neglect. There was no guidance for staff about how to support this person during these times other than to say, "(name) your bath is ready". However, staff reported this person had not been able to use the bath in their en-suite room as the recently fitted handrails had not been assessed by the occupational therapist as safe to use. Staff reported that they did not know how well this person was attending to their own personal hygiene needs as they had frequently refused staff's offer of assistance. Following the inspection, the registered manager confirmed an occupational therapist had assessed the handrails as safe to use and the person had been more accepting of staff support with their personal hygiene.

A document entitled "Guide to a good day" was designed to provide staff with guidance about how to positively support this person to reduce episodes of social isolation, self-neglect and anxiety. This guidance was based on the person's abilities and level of interaction prior to them moving to the service, not their support needs at the time of the inspection. Staff told us this guidance was no longer suitable and if they followed it, they were likely to cause further anxiety to this person. For example, the section entitled, 'How can you help me' discussed encouraging the person to come downstairs and assist with meal preparation. However, this was out of date as it referred to the person's previous service. Staff said the person was very reluctant to come out of their room when the other two people living in the same bungalow were present. The guidance did not reflect how staff were supporting this person when they did choose to come out of their room and what approach staff had found to be successful. While some handwritten changes had been made to the document with some of the sections no longer relevant crossed out, information and guidance

more accurately reflective of the person's needs had not been added.

Relatives and advocates felt there was not enough opportunity for people to go out of the service. One said, "I'm concerned he never goes out unless it's with me." Another said people "just sit around watching TV" and there was little staff interaction. An internal audit in July 2016 identified that there were limited opportunities for people to engage in social activities. We looked at how the service supported people with engagement in activities meaningful to them and promoted their involvement with their interests. One person's care plan identified they liked to go to the local town to shop. There was no reference in their daily care notes, other than a reference to going to a Christmas meal organised by the service, that this person had been out of the service during December. Staff recognised that opportunities to go out of the service were limited due to staffing levels. They also said there were some limitations to using the service's minibus to take people out. If doctors or hospital appointments were necessary, the minibus was used for these and therefore wasn't available for people to use.

Failure to provide care and treatment that is appropriate, reflective of people's preferences and meets the needs of all those using the service is a breach of Regulation 9 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

People's care plans included information about people's interests. One person's said they enjoyed reading books, motor sports, rugby and golf. However, their care plan did not provide staff with guidance about how to engage this person with these topics. From the daily care records we looked at it was not possible to gain a full picture of how people spent their day and how staff supported people with meaningful engagement. The registered manager said that as staff knew people well, they naturally provided people with items of interest or sat with people, however they did not always records these interactions. During our inspection an aromatherapist was visiting the service. They said they visited each week and people enjoyed the massage sessions.

Other than feeling people should have more opportunities to go out of the home, relatives and advocates told us they had no complaints about the care people received. They said they could talk to the registered manager if they did. One relative said, "none whatsoever" when asked if they had any concerns about how well the service cared for their relation. Not all of the people receiving support were able to raise concerns themselves. However, staff told us they would recognise if people were unhappy by their body language and general demeanour and would discuss this with the registered manager. The registered manager told us the service had not received any complaints this year.

Requires Improvement

Is the service well-led?

Our findings

During this inspection we identified a number of areas relating to people's care and support that required improvement. For example, staffing levels did not ensure people received responsive and consistent care and there were limited opportunities for people to be engaged in activities. An internal audit by the area manager in July 2016 identified this and we found this was still a concern of relatives, advocates and staff in December 2016. Documentation that guided staff about how to support people safely was insufficiently detailed and at times out of date. People's capacity to consent to activities carried out in connection with their care needs had not been assessed. Systems in place to assess quality and risk had not identified this.

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

Although staff, relatives and advocates had some concerns over the staffing arrangements at the service they told us they felt the service was well managed. One relative described the service as "excellent in the way it's run" and an advocate said of the registered manager, "I really rate [name], she has standards." The registered manager was supported by a deputy manager who worked four days a week: one working alongside staff and three in the office undertaking administrative duties. The registered manager said they were well supported by the provider's area manager who regularly visited the service to review people's care and undertake quality audits. These meetings were used to review people's care and support needs and to review how the service was performing in line with CQCs key questions. The provider also had a quality monitoring team from whom the registered manager was able to seek guidance and advice. This team periodically sent out questionnaires to people's relatives and staff to gain their views about the service. We reviewed a sample of those returned during 2016 and saw these gave favorable feedback about the service.

Regular staff meetings gave staff and the registered manager the opportunity to discuss people's care. Staff were invited to share their views about 'what was working well' and 'what was not working'. In the minutes from the meeting held on 12 December 2016 staff had requested face-to-face training about supporting people with epilepsy and the registered manager confirmed this had been arranged.

Staff told us they enjoyed working at the service and were well supported. They said the registered manager was approachable and always had time for them. They confirmed the registered manager worked alongside them to ensure good standards were maintained. One staff member said, "It's a nice place to work, I like it here" and another said, "I really like working here, we're a good team". They confirmed they received regular supervision and an annual appraisal and we saw records of these in staff files. Staff said they had the opportunity to discuss their role and their training and development needs at their supervision sessions but also at any time with the registered manager.

The registered manager undertook a number of audits of, for example, of medicines to ensure they had been administered as prescribed; care plans to ensure they provided an up to date description of people's needs, as well as health and safety issues such as equipment testing and servicing. In the Provider Information Return, the registered manager said the provider sent a regular report to the service which

provided information about current good practice and updates within Health and Social Care. The registered manager was aware of their responsibility regarding duty of candour, that is, their honesty in reporting important events within the service, and their need to keep CQC up to date with important events within the service.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received care and treatment that was appropriate to meet their needs and reflected their preferences. This included opportunities to spend time outside of the home. Regulation 9(1)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff failed to demonstrate a respectful relationship with all of the people living at the service. Regulation 10(1)(2)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to improve the quality of the service. Where improvements had been identified, the provider had not taken action to address these issues. The provider had failed to take action to mitigate known risks to people's safety and welfare. The provider had failed to ensure accurate, complete and contemporaneous records were

	maintained for each person. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide sufficient numbers of staff to meet people's needs. Regulation 18(1)