MacIntyre Care

Hubbard Close

Inspection report

15 Hubbard Close
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service in December 2015 and rated the home as 'Good' overall. At this inspection, on 20 September 2018, we rated the service as 'Requires Improvement' overall. This is the first time Hubbard Close has been rated as Requires Improvement. This inspection was announced the day before we visited. This was to ensure a member of staff would be present to let us into the home.

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

Hubbard Close provides personal care and accommodation for people who have a range of learning disabilities. Hubbard Close can provide care for up to five adults. At the time of this inspection five people were living at the home. Hubbard Close comprises of accommodation over two floors.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy.

There was a registered manager in place when we inspected the home. 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.

People's risk assessments and the care plans created to guide staff about how to manage and respond to certain risks, had not been updated or were not completed fully. A plan to manage a person's safety in the community was not robust.

The service was not compliant with the Mental Capacity Act 2005. An activity a person engaged with was being controlled by staff. The persons' ability to agree to this restrictive plan had not been checked. They had not been involved in this plan. The plan was not being reviewed on a regular basis. There were gaps in the recording of some people's capacity assessments. It was not always clear that these assessments were robust. Even though, these assessments were considering if people could make certain important decisions about their lives.

The provider and registered manager's audits were not always effective or thorough. At times, these audits did not always consider if people's experiences could be improved upon or lead to action to try and make this happen. People were funding elements of their care rather than the provider looking at alternatives to this.

These issues constituted breaches in the legal requirements of the law. There were three breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

There were various safety checks taking place to ensure people received safe care and support. However, there were some shortfalls in this area. These related to timely action to issues identified about the building, infrequent fire evacuation drills, and gaps in people's risk and care assessments. Lessons were not always being learnt or considered when incidents took place affecting the people at the home.

Staff recruitment checks were not complete or well evidenced. We made a recommendation that the service improved this aspect of people's safety.

People received support to access health care services when they needed this input. Staff also followed up concerns and outstanding issues in relation to people's health needs.

The service was involving people with what foods were available to them and they were promoting healthy options. People told us that they really enjoyed the food at the home.

The registered manager and staff were kind and thoughtful to the people at the home. They treated people as adults and they had clearly developed kind and respectful relationships with the people living at Hubbard Close.

We did find that there was an issue with how the service stored people's confidential information. However, this issue was resolved shortly after we inspected the service.

People appeared to be involved in the planning and reviewing of the care and support they received. People's assessments explored people's interests, likes and dislikes. We were told about how staff promoted one person's potential, however staff were unable to give us other examples of this in relation to other people at the home. This aspect of people's care was not being routinely explored by the provider or the registered manager.

Some people had end of life plans in place. However, we found these were not always person centred. We made a recommendation for the service to review these plans. People's rooms were not always promoted as personal spaces. The décor in people's rooms was tired.

There were regular activities taking place at the home and people often attended the provider's learning centre.

The registered manager was available and present around the home. There was a positive culture at the home, but the service was not always considering how or if they could do better for the people who lived at Hubbard Close.

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's risk assessments were not up to date and they did not always give clear guidance to staff about managing these risks.

A plan to manage a person's safety when they were out was not robust.

Safe recruitment checks on staff were not complete.

Incidents were not analysed to see what lessons could be learnt or to see if elements of people's care planning could be improved upon.

Some elements of fire preventions were not completed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to make certain decisions was not always assessed and reviewed effectively.

Staff maintained control over a person's daily activity. This had not been appropriately assessed and the person had not been involved in an open and meaningful way with this restrictive plan.

People had access to health care services when they needed to.

People enjoyed the food and healthy options were promoted at the home.

Is the service caring?

Good

The service was caring.

Staff were kind and thoughtful towards the people who lived at the home.

Staff treated people with respect.

People's confidential information had not always been stored securely.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People had end of life plans in place, but these were not person centred.

People's rooms were not always valued as their spaces.

People interests and likes were identified.

Activities and events were planned to meet people's interests.

People were asked about their views of the care they received.

There was a complaints process at the home which people used.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider and registered managers audits were not effective or robust.

Action was not taken in a timely way or considered when issues arose about the building.

There was a positive culture at the service.

Hubbard Close

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 checked 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 site visit took place on 20 September 2018. We gave the service 19 hours' notice because the home was small and people could be out during the day. We needed to ensure a member of staff would be present to let us in.

The inspection team consisted of one inspector.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service and we took these into account when we inspected the service. We looked at the notifications sent to us over the last two years. Notifications are about important events that the provider must send us.

During the inspection we spoke with three people who lived at the home. Some people could not communicate with us in ways which we could understand. As a result of this, we completed observations throughout our inspection. We spoke with two members of care staff and the registered manager. We looked at the care records of two people in depth and another two people's records about specific issues. We also looked at the medicines records of three people and the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and safety records completed at the home.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Requires Improvement

Is the service safe?

Our findings

We inspected Hubbard Close in December 2015 and found that the service was safe. When we inspected in September 2018 we found some areas which required improvements to be made.

The service had risk assessed people's needs. Care plans has been written for staff to follow in order to guide staff about how to manage some of the risks which people faced. However, from the sample of two people's care records we looked at in detail, we identified three risks which were not explored. One person could present themselves in a certain way when they were anxious. This could lead to them harming themselves. We saw this recorded in accident and incident records. On one occasion this person had harmed themselves. The recording of this incident was powerful. On another occasion due to a similar presentation a member of staff needed to leave the home for their own safety. We looked at their risk assessment. This risk had not been covered in detail. There was a plan how to reduce this person's anxiety, but not how to manage them hitting themselves. There was no guidance for staff to follow after this event to ensure this person was safe. There was a real risk that this person could inadvertently sustain a head injury, and yet there was no robust plan to manage these situations. There was no post analysis following these events to try and prevent this kind of behaviour happening again. There was also no review of this person's needs.

This person had experienced an assault later last year when out in the community. This event had not triggered a review of their risk and care assessment when they were out in the community alone. The ability for this person to remove themselves from risky situations had not been explored with this person. Nor had this person's understanding of risky situations been assessed.

The registered manager told us what the plan was to manage this person's safety if they went missing in the community. We also looked at this plan. This plan gave some guidance for staff to follow if this person did not return to the home. This plan asked staff to refer to other guidance. We asked to see this 'other guidance.' This other guidance made no reference to important practical steps to help ensure this person was found and was safe. There was not one detailed plan for staff to access and follow in this event. When this person went out the emphasis was on them calling the home. There was no recording of when this person called the home or where they were at that time. There was no real oversight of this issue. This plan to manage this risk was not robust and had not been reviewed following their assault last year.

We looked at another person's risk assessment. We could see that the registered manager had identified a particular risk to this person's safety and had taken action. They had made a referral to a specialist health professional to support the staff to manage this risk. However, in the meantime before the health professional made contact, there was no review of this risk with a plan for staff to follow should this risk arise.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with two members of staff who had a good knowledge of how to protect people from potential abuse and harm. These members of staff told us what the potential signs could be that a person was experiencing abuse. Staff told us that they would report it to the registered manager straight away. However, another member of staff said they would also speak with other members of staff just before they reported their concerns to the registered manager. This is not good practice as this could interfere with a potential safeguarding investigation. Staff were aware that there were outside agencies they could also report their concerns to, one member of staff knew who these were including the local authority safeguarding team. Unfortunately, another member of staff could not recall this information. Staff should have a very clear understanding about what they can do if they have concerns about potential abuse.

The staff we spoke with and the registered manager had a clear understanding about what discrimination meant for the people they were supporting. However, when we asked staff and the registered manager about 'hate incidents and hate crime' with the exception of one member of staff, they did not have a clear understanding of this. One member of staff said, "I have not heard of that terminology before." We explained what this meant. This member of staff then stated they were not aware of 'hate incidents or crime.' A person had potentially experienced a hate crime last year. However, staff and the registered manager were not fully aware of what this really meant.

During this inspection we looked at how people received their medicines. We looked at three people's Medication Administration Records (MAR). One person had two missing signatures in September 2018 for a prescribed product. Another person did not have the total of their prescribed medicine carried forward on their MAR. There had been medication audits completed, but these issues had not been identified with action taken to prevent these issues from happening again. Despite this, we did a count of people's medicines and found the remaining medicines tallied. We concluded that people did receive their medicines as prescribed, but further work was needed with the auditing of medicines.

During our visit we identified two issues which could have had a negative impact on a person's safety. A member of staff was hoovering in a hallway and leaving a taut and later loose electrical cord in a hallway for some time. A person in the home could have tripped on this. Also, a used power adapter had been placed under a heater which was on. The power adaptor was warm to touch. This had the potential to cause a fire and was not safe practice. We spoke with the registered manager about these issues. They turned the heater off, but did not remove the adapter. We suggested they moved the adapter. They said that they would do this and they would speak with staff about these issues.

There were various safety checks which were taking place. The fire service had visited the home in June 2016 and said the home at that time was safe. People had personal emergency evacuation plans in place (PEEPs). The landlord had arranged for specialist fire safety company to visit the home. They assessed how safe the building was in relation to the risk of a fire. They made recommendations, one of which the registered manager had taken some action on. This was the removal of portable electric fires. However, we found that one person still had one of these fires in their room near their bed. There was no additional risk assessment in relation to this. The registered manager was also still chasing the landlord to resolve another issue that had been identified in this fire risk assessment. The registered manager told us that they ought to get in touch with the fire service to request another safety visit, but they had not done this. They could not explain why they had not done this, even though the landlord had found some issues.

We could see that there were weekly tests and checks taking place in relation to the fire equipment at the home. There had been regular fire drills involving the people and staff at the home.

During the inspection we asked the registered manager if there were checks that the service was free of

Legionella. This is a bacterium which can cause people to become unwell. The registered manager sent us confirmation that this test had taken place this year.

There was an emergency contingency plan in place. We looked at this document and there was a record to say staff had read and understood these individual plans. However, there was no plan in place to manage a sudden reduction of staff, or if there was a severe weather event. We spoke with the registered manager about this. They said there was a plan in relation to a sudden reduction of staff. When they sent us this document this was in fact an assessment of staffing levels. There was no step by step plan to manage these emergency situations if they happened.

We looked at the recruitment checks completed when staff started working at the home. The registered manager told us that they ensured these checks were in place, but there was no record of this available at the home. We therefore could not be assured that these checks had taken place. We spoke with the registered manager about this who told us they would ensure there was a record of these available at the home in the future.

The provider was also not requesting a full employment history check on new staff. The registered manager told us that they only did check for any gaps in employment within a five or a ten-year period. They later showed us a potential new employee applicant where they said they had explored a gap in their recent employment history. However, we identified a further gap in their recent history which had not been identified. These are all important checks to ensure people are safe around staff. We recommend that the service consider current guidance when completing security checks on staff.

During this inspection we considered whether the home was hygienic and clean. We found that the home was clean. However, we noted that in two people's rooms there were large cob webs. The registered manager told us that one person will not let them go into their room. However, this person invited us and the registered manager into their room during the inspection. Another person had an extractor fan in their bathroom which was dirty. The registered manager told us that they would ensure that these issues were resolved.

The registered manager had completed a risk assessment in relation to staffing levels. We found that there was an appropriate level on staff on duty. We saw this level of staffing was repeated when we looked at the historic staff rotas. We were told about the plans which were in place if staff requested advice or support out of office hours.

The people we spoke with indicated that they felt safe. One person said, "Yeah" to this question. Another person nodded their head when we asked them if they liked living at the home. We observed that people living at the home were familiar with staff. This indicated to us that people felt safe at the home.

Requires Improvement

Is the service effective?

Our findings

When we inspected in December 2015 we found that people received effective care. When we visited in September 2018 we found some areas where improvements were required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

One person was choosing to smoke and had done so for a long time. This person was having their cigarettes rationed by staff daily. The registered manager told us that this practice had been taking place for a long time. At one point the registered manager told us this was because they were expensive to buy, and then later because this person would smoke a lot if the supply of cigarettes was not controlled. We looked at this person's care record and found there was no capacity assessment completed to check if they had capacity to agree to this practice. There was also no evidence at their reviews if they were able to or consented to this practice. We also saw recorded in the staff minutes of meetings that staff were being criticised for restricting this person's cigarettes beyond the 'agreed' amount. Although it was positive to see that this practice was being challenged, it still did not lead to a review of this situation to ensure this person's rights in this way were being promoted and protected.

We spoke with the registered manager about this. They had an understanding that this person had been involved in this plan historically but they did not know for certain. They were also unable to evidence this. They also agreed that this 'plan' had not been reviewed for some time. They agreed this 'plan' should be being reviewed on a regular basis. The registered manager also told us that this person was assessed as lacking capacity to manage their money. This had not triggered a review of their capacity to agree to this plan or arrangement. This is not good practice or reflective of the principles of the MCA.

Another person was considered not to have capacity to make specific decisions about their finances. A relative had been given legal powers by the courts to make these decisions on this person's behalf. There was no evidence of this in this person's records at the home. This person's arrangements were changing, but the registered manager did not have an update on this. They were not monitoring its progress. They and another member of staff told us that they did not believe the new arrangements for this person would work. They had not shared these views with the relevant parties or tried to consider alternative arrangements for this person, involving them, their family, and the local authority.

We also saw a current capacity assessment completed for this person by a member of staff at the service. In this assessment it did not clearly record who this member of staff spoke with when consulting with other professionals and people involved in this person's life, when making the decision that they lacked capacity to make a specific decision. We looked at another person's capacity assessment in relation to managing

their money. This was reviewed each year. However, there was no evidence to say how this was reviewed and if the person had been involved in this assessment.

The above issues constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 homes 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.

When we spoke with staff about their understanding of MCA and DoLS. The staff we spoke with had a good understanding of this. They told us how they promoted and encouraged people to make choices with their day to day lives. One member of staff told that, "It's about standing back and offering help, not assuming people need it."

We concluded that further work was required to ensure the service was compliant with the MCA.

People had access to health services. We saw examples of planned routine appointments being made and taking place. A referral had been made for one person to see a professional because they were in pain and discomfort. We saw in their records that this was followed up until the issue was resolved.

The staff we spoke with spoke positively about their training and their inductions to their work. We could see that staff training was up to date and this included subject areas relevant to the people living at the home.

We were told that staff competency was assessed in key areas such as medication, safeguarding and mental capacity. However, the evidence to show how a member of staff was competent in these areas was not always recorded. We were told that the competency of new staff during and after their induction to their new jobs was assessed. The registered manager told us that they were unable to show us these records as the service did not keep a copy of these records at the home. We spoke with the registered manager about these issues. They agreed that the systems to show staff were competent needed to be improved and available at the home.

We asked some people about their views of the food. One person said, "Food, love it." Another person told us that, "I like the food, pasta, I eat healthy now."

People were supported to have enough to eat and drink. The registered manager showed us how people chose what they wanted to eat at a weekly meeting at the home. Staff were trying new recipes and had printed the picture of these foods from a website. We saw a member of staff cooking one of these meals later that evening. Although this was positive, the menu on the wall was not in a format that people could all read and understand. It was written in small writing on a blackboard. We were later told that the picture of the evening meal should have been attached near this board. This was not the case during our inspection at the home.

Both staff and the registered manager told us how healthy foods were promoted at the home. We could see that staff were trying to promote these foods at the home.

When we were shown the garden, the registered manager had told us how a person's relative had donated

funds to enable the garden to be altered to enable people to make more use of it. The garden was now on three levels, which people could access via steps. However, we were told that not everyone at the home liked to use these steps. The registered manager said they were considering having a rail fitted. However, no real action had been made to make this garden fully accessible.

Good

Is the service caring?

Our findings

When we inspected Hubbard Close in December 2015 we found that the service was caring. When we inspected the home in September 2018 we found this was still the case.

People told us that they liked the staff who supported them and they liked living at the home. One person said, "I'm proud of living here, that's good ain't it." We later asked this person about the staff at the home, they said, "I like them all." Another person said staff were, "Kind" and "Lovely." A further person told us, "I love it here, nice and warm."

We found that staff treated people with kindness and thought throughout our time at the home. Staff spoke in a gentle but adult way with the people who lived at the home. One member of staff was helping a person clean their room. They needed to answer a phone, they apologised and said they would be back shortly, which they were.

During the inspection we saw staff knocking on people's doors and waiting for a response. Staff told us how they promoted people's dignity and privacy when they were supporting them with more personal care. Staff also told us how they would make other checks about a person's well-being in a way which would not undermine their independence or privacy. When we were present in the kitchen the groceries were delivered. One person began to put these items away. A member of staff offered their support in a respectful way encouraging this person's independence with this task.

We spoke with one person who told us, "I like it here, coz I can do as I want, come and go as I want." People were supported to be independent when appropriate. We saw another person go shopping with a member of staff. When they returned they showed another member of staff what items they had brought for themselves. They looked pleased about this. Another person supported staff with certain safety checks in the home. This person also administered their own medicines. The registered managed showed us how they were also involved in the checks that the registered manager completed to ensure they had had their medicines.

People had weekly meetings to express their views about the support they received. We looked at a sample of these meeting's minutes. These were written from people's perspectives. However, these were not written in formats that people could understand and then shared with them.

People's information was stored in a locked cupboard within the office on the first floor. Although, these files faced a window which at the time of the inspection could not be locked and was wide open. The registered manager later sent us information to show this window was fixed and this information was now secure.

Requires Improvement

Is the service responsive?

Our findings

When we inspected Hubbard Close in December 2015 we found that the service was responsive to people's needs. We found this was still the case in some areas when we inspected in September 2018, however, there were some areas where improvements were required.

At this inspection we found that people had care assessments in place. We saw examples of people being involved in their care planning. People had one to one meetings where they would discuss with a member of staff their needs and goals for the future. Staff would check at these meetings if these goals were being met. People also had yearly reviews when they would express their views on the service and support they were receiving. We could see from looking at these documents that people were involved as much as possible. Their views were expressed and recorded. Pictures were used to represent what people had said. On one person's review pictures had been cut up and stuck on their review to express their opinions about the care they received.

People's care assessments we looked at, had identified what people's likes and interests were. On the day we visited we saw one person go out to explore their interest. Another person went shopping to buy items for themselves. People returned from a learning centre, and were making plans to attend a weekly event with their friends. These people appeared excited about going to this event. They told us what they were going to do at this event and who they were going to see.

We asked staff how they supported people to realise their potential. Two members of staff told us how they supported one person to write letters to their relative. These members of staff explained to us how this was achieved as a result of their input over a long period of time. However, staff were not able to give us other examples of how they supported people to fulfil their potential.

People did access social events and were able to maintain existing friendships through the support they received at the home. Most people went to a learning centre owned and run by the provider, alongside the support they received from the home. This support was not separately funded or arranged by the local authority. If people decided not to go, they stayed at the home and were supported by staff. The home was recording people's social experiences. When we looked at this record for July to when we inspected the home, we saw a range of social events taking place. The previous months had shown routine appointments rather than social opportunities. The registered manager told us that this was a recording issue, and staff were now recording what people were doing to meet their social needs.

With the exception of one person, people had chosen to have a short holiday this year. People paid for this themselves. This involved people saving throughout the year to achieve this. However, the provider was not considering alternatives to fund this support. People were expected to pay for elements of their care such as new mattresses and staff time when on holiday.

During the inspection we visited people's rooms. Two people also showed us around their rooms. These

were personalised spaces reflecting their interests and what they liked. However, we did note that in two people's rooms boxes of disposable gloves for staff to use were on display. One was on the top of a person's wardrobe. This practice is not respectful of people's personal spaces.

We found that people's bedrooms and parts of the home's communal areas looked tired with marks and chips on the walls. The registered manager told us that people had chosen the décor when they moved in. However, people's décor was largely of the same magnolia colour. We spoke with the registered manager about this. They agreed that the rooms and communal spaces, "Looked tired." They showed us the kitchen and dining area which was redecorated last year. People were deciding how to decorate the living room when we visited. One person we spoke with confirmed this and looked excited about this prospect. We asked why the other rooms had not been considered. The registered manager was not clear on this issue. They confirmed there were no plans to complete this work at present. They told us that they would discuss this with the provider.

We were told that people had end of life plans in place if people wanted them. We looked at one person's care record who had said they had declined to have this plan. Their record did not show how this idea was discussed with this person, or how it was revisited. Another person had a plan in place, we could see they had identified certain aspects of this care which was important to them. However, some further information was not explored to enable staff to fully know their wishes. We spoke with the registered manager about this. They told us that this person would not be able to express this information. They told us what this person's likes and interests were, yet the service had not considered exploring these with the person and making this relevant to this plan. People's plans did not explain where they wanted to be cared for towards the end of their life or who they wanted to be involved during this part of their lives. We recommend that the service seek advice and guidance from a reputable source about how to create end of life plans for people at the home who wanted them.

There had been no formal complaints made at the home. We were told that people were asked if they were happy and if they wanted to talk about anything that they were not happy about at the house meetings. The registered manager told us that people would tell staff if they had an issue. A person we spoke with confirmed this. The registered manager said they were working with the provider in terms of formalising some of the "Niggles." We asked if the complaints process was explained to people in a way they could understand, the registered manager told us that it was. However, when we looked at meetings and people's reviews, this was not recorded.

Requires Improvement

Is the service well-led?

Our findings

When we inspected Hubbard Close in December 2015 we found that the home was well led. When we visited the home in September 2018 we found some areas where improvements were required.

Some people did not have full risk assessments in place with accompanying plans for staff to follow to help reduce certain risks which people faced. These plans had been reviewed but these issues had not been identified by both the registered manager and the provider. A person had experienced an assault and there had been incidents relating to their actions. There was no real post analysis from these events to look at what could be done to prevent a similar event occurring again.

A person's access to their cigarettes was being controlled by staff. This had not led to a capacity assessment or full consultation with this person about this control. A decision was made on another person's behalf to not pursue the purchase of a new bed. This decision was also made without fully consulting with this person. A further person's control of their finances was not being monitored and checked by the service. The leadership of the home were not taking any actions to promote this person's interests to create a workable plan for this person. Some people's capacity assessments were not detailed. There was no evidence of who was consulted with when determining a person's capacity about a specific decision. Reviews of these decisions were not robust and meaningful.

The registered manager had identified that there was an issue with the windows at the home. No real action was taken to resolve this issue for the winter. The provider had requested quotes in April 2018 yet still this issue had not progressed. The condition of the windows was identified the winter before. No action had been taken. The landlord had identified a fire safety issue. The landlord had not resolved this issue quickly. The décor was tired and people's rooms were not personalised in this way. The registered manager had identified this issue but no action had been taken to address it. The garden was not fully accessible, this issue had been identified but no action again had been taken. We were told that the landlord took time to resolve issues about the building. The provider had not resolved this issue.

We noted that people had to pay for elements of their support but the provider and the service had not considered other ways to fund this support such as involving other organisations. For example, people saved all year for their holidays. The cost of these holidays included staff time, staff food, staff accommodation, and the cost of staff to accompany people to events whilst on holiday and outside of holiday times. A person had to pay for new curtains in their room, another person was going to have to pay for a new mattress but it was decided by staff that due to the cost of their holiday this purchase would be "shelved." Rather than the provider paying for this or third-party alternatives considered and pursued. In these ways the provider was not fully promoting and championing the individual person.

Recruitment checks to ensure people were safe around staff were not evidenced. There was no record to show that these checks were completed. The provider was not asking for full employment histories from new staff and gaps in employment were not being identified and checked. Staff competency checks were

not always well evidenced.

The provider and registered manager was not completing robust audits and checks of people's records, reviews, one to one meetings records or assessments. The provider and registered manager were also not always meaningfully considering people's experiences with a view to see if these could be improved upon. If they had, they would have identified the issues which we had during this inspection.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a positive culture in the day to day running of the service. Staff treated people with kindness and respect. People told us that they enjoyed living at the home and being among the staff and the registered manager. The registered manager was approachable and present in the service. They were knowledgeable about people's needs and had developed good relationships with them.

The registered manager was aware of the important events they must notify the commission about by law.

People accessed local community resources, and other services owned by the provider. However, partnership working with other organisations and other charities was not taking place.

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 Regulation 11 HSCA 2008 (RA) Regulations 2014: Need for Consent Care and treatment must be provided with the consent of the relevant person. Regulation 11 (1) (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was always provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider did not always have effective systems and processes in place to monitor and improve the safety and the quality of the

service.

Regulation 17 (1) and (2) (a) (b) (c)