Caulfield & Gopalla Partnership

Newnton House Residential Care Home

Inspection report

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Date of inspection visit:
14 March 2017
16 March 2017

Date of publication:
26 April 2017

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

Summary of findings

Overall summary

We carried out this announced comprehensive inspection on 14 and 16 March 2017.

Newnton House provides care and support for up to 9 people with mental health needs, many of whom have a forensic history and learning disabilities. The service aims to provide a short-term service for people before they are able to live more independently. At the time of our inspection there were nine men using the service, and two people received support with personal care. The service is based in a large house in Hackney, which contains nine bedrooms, three bathrooms, a large lounge and activities room, a kitchen and dining area and a communal garden. There was a staff office within the building and a staff sleeping in room, with a manager's office in a shed at the end of the garden.

The service had a registered manager who had been in place since November 2015. 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.'

At our previous inspection in October 2015 we rated this service "Requires Improvement". We found a breach of regulations with regards to notifying CQC of significant events which had occurred in the service, and made recommendations about the management of medicines and providing activities to people. We found that the provider had taken satisfactory action in response to the last inspection report.

We found that there were measures in place to ensure the safety of the building and risks to people who used the service had been assessed. However, these risk management plans were generic in places and although a number of people had behaviour which may challenge there were not detailed plans in place for recognising the signs that a person may be about to become challenging or how to deescalate the situation. Accidents and incidents were recorded, but in some instances actions required in response to these had not been carried out, and the recording of incidents did not always record the circumstances which had lead up to an incident, which would be useful for developing plans to manage people's behaviour.

Staffing levels were adequate to meet people's needs and appropriate checks had been carried out of the suitability of staff. People who used the service told us they felt safe there and were treated well by staff. People benefitted from a small, stable staff team which allowed good caring relationships to develop. Staff promoted people's dignity and privacy and maintained confidentiality. Staff received training in line with the provider's policy and regular supervision and appraisals, but the provider's policy did not fully assess the training needs of the staff team in line with working with people with mental health needs.

We found that care plans documented people's needs, including their activities and there were tools for monitoring their recovery. However, we found that the service didn't always document people's preferences or have plans in place to communicate with people who had difficulty speaking, hearing or reading. This

meant we could not be certain that people had always understood the contents of their care plans before they had consented to these. Where people were deprived of their liberty in their best interests, the provider had taken appropriate measures to do this lawfully. When people were free to leave the service, the provider took measures to ensure people were safe, including monitoring when they had left and following missing persons plans when they had not returned. Medicines were safely managed by staff who had the appropriate training and skills to do so, and this was checked by a pharmacist regularly.

The provider worked with mental health teams to monitor people's health and promote recovery, and there was good communication of how people's needs had changed. There was a complaints policy in place, and people were confident in approaching managers with concerns, but the provider did not record informal concerns or verbal complaints. People were supported to speak up through keyworking, residents meetings and had access to advocacy services.

We made a recommendation about how the service records verbal complaints. We found breaches of regulations in relation to safe care and treatment and person centred care. 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 safe in all aspects.

The provider had measures in place to safeguard people from abuse and carried out health and safety checks to ensure the safety of the building. People were supported by sufficient numbers of staff to meet their needs, and the provider checked staff were suitable for their roles.

Risk assessments were reviewed regularly. However, these did not always contain sufficient strategies for managing and preventing behaviour which may challenge.

Medicines were safely managed by staff who had the skills and knowledge to do this.

Is the service effective?

Good

The service was effective. Staff received regular supervision and training which was monitored by the provider, although the provider had not assessed staff training needs in relation to the needs of people who used the service.

Where people had restrictions placed on their movement, this was carried out in line with the Mental Capacity Act (2005) (MCA).

People were supported to maintain good health, and medical treatment was sought when staff had identified concerns.

Is the service caring?

Good

The service was caring. People told us the staff team were approachable and helpful.

The service benefitted from a stable staff team who knew people well. We observed friendly and respectful interactions between staff and people who used the service.

There were measures in place such as keyworking, advocacy and residents' meetings to support people to speak up.

Staff promoted people's dignity and privacy and took measures

to protect confidentiality.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

People's support plans were goal orientated and measured people's progress and development in key areas. The provider had worked with other agencies to respond to changes in people's needs. However, plans did not contain sufficient information on people's preferences, likes and dislikes. There was limited use of communication tools and accessible formats.

There was a complaints policy in place, and people knew how to complain. However, verbal complaints were not recorded.

Is the service well-led?

Requires Improvement

The service was not well led in all aspects.

Managers were visible in the service and people were comfortable approaching managers with their concerns.

There were systems in place to ensure that tasks were completed and that communication was maintained with the staff team. Managers had carried out customer satisfaction surveys. The provider carried out an external audit quarterly, however these did not detect issues with risk assessments and the use of accessible communications.

Notifications had been submitted to the Care Quality Commission of significant events.

Newnton House Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 16 March 2017. The provider was given 48 hours' notice of the inspection as the location provides a service for younger adults who may be out during the day, we needed to be sure that someone would be in.

The inspection was carried out on both days by a single Inspector. Prior to carrying out this inspection we reviewed information held by the Care Quality Commission about the service, including notifications of significant events. We spoke with one monitoring officer from the local authority.

In carrying out this inspection we spoke with four people who used the service and two of their relatives. We reviewed records of care and support relating to three people and records of medicines management and storage relating to nine people. We reviewed records of recruitment and supervision for four staff and training records for the whole staff team, and records relating to the management of the service including rotas, handover documents, health and safety checks and audits. We spoke with the registered manager, the deputy manager and one care worker.

After the inspection we made calls to two relatives of people who used the service and two health professionals who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

We found that the provider had measures in place to keep the service safe, but did not always assess and manage risks effectively. The provider had carried out risk assessments around the safety of the building, and there were also risk assessments for each individual. Risk assessments identified the need for staff to be alert to the signs of a deterioration in people's mental health and to monitor people's compliance with their medicines and, where necessary, to escort people to access the community. Staff we spoke with understood people's mental health needs and possible triggers for behaviour which may challenge the service. Comments included "You have the care plans so you know the relapse signs" and "Beyond that we call the Mental Health Team." We found that guidelines were in place for managing one person's inappropriate behaviour and the effectiveness of this was monitored through support plans. One professional we spoke with said "There are a few residents who can be quite challenging at times, and staff manage that well."

However, we found that measures to mitigate the risk from people's behaviour were not always well documented and plans were often generic. For example, three plans stated that the person should "develop therapeutic relationships to explore alternative coping strategies" and "attend keyworking meetings", we saw that keyworking meetings were taking place but there was no further evidence of how alternative coping strategies had been developed. In some cases other people's names were used in risk assessments, indicating that this text had been copied and pasted from other people's plans. Staff told us about one person, "Mentioning [nationality] is a big trigger for him" but this was not recorded anywhere in the plan. Several plans mentioned the need to contact the police in the event that staff were unable to manage a person's behaviour, but there were no steps in place for avoiding triggers, detecting the warning signs that a person may become challenging, or guidance about how to de-escalate the situation. One person's file contained a detailed behavioural management plan which was from their previous placement, however this had not been updated or carried through to the person's new plan.

In response to a complaint against a member of staff, the provider told us that one person had a history of making inappropriate complaints and referred us to the person's risk assessment. However, this assessment did not have clear guidance for ensuring that staff acted in a way which would manage this behaviour. This person's care plan approach stated that they had a history of making threats against staff, but the risk assessment did not have steps in place to mitigate this, although the provider maintained an up to date progress report of untoward and potentially challenging behaviour. The provider told us this risk assessment was completed before the person moved to the service a year and a half ago and had not yet been updated, although staff now knew the person well. In response to one incident, the incident report stated that the provider was to put a behavioural management plan in place, but this had not taken place.

Where incidents had taken place, the provider completed a record of these, including the person who was involved in the incident, any witnesses, a description of what had occurred and remedial action taken, and whether staff now considered the danger was removed and the service now safe. However, this format did not include a description of the events that occurred leading up to the incident, information which would be important for implementing and monitoring behavioural support plans. The provider told us they intended to introduce an Antecedent-Behaviour-Consequence (ABC) style chart for recording incidents.

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

The provider maintained a missing person's plan, which included a description and information on the person's diagnosis, medical needs, medicines and any risk they may pose to themselves and others. In response to a recent incident where a person had failed to return to the service, this had been appropriately reported to the police and CQC, and the risk assessment had been updated to state that the person would now be supported by staff when leaving the service, which was taking place.

People who used the service and their relatives told us that they felt safe there. Comments included "Yes I think it's safe" and "Yes it's safe, I'm OK". Staff members we spoke with agreed it was safe.

Staff had received training in safeguarding adults and were able to recognise the signs that a person might be being abused and understood their responsibilities to report their concerns. A care worker told us "I think they'd take it seriously". Where abuse was suspected, including incidents of theft and violence between people who used the service, the provider had met their responsibilities to report these to the local authority and the Care Quality Commission (CQC).

The provider maintained a check sheet for ensuring that key checks to the safety of the building were up to date. This included employer's liability insurance, emergency lighting, portable appliance testing, fire alarm and fire detector testing, checks of fire extinguishers and gas and electrical safety. Staff had received training in health and safety and fire safety training, and carried out weekly tests of the fire alarm including checking call points on a rotating basis and ensuring that fire doors had closed automatically. Staff conducted quarterly fire drills in the service including recording whether people had been able to evacuate the service and follow instructions, and had scheduled future dates for these to take place. There was clear evacuation signage in place. The provider had commissioned an external agency to carry out a fire risk assessment in September 2015, we checked that some of the points for improvement had been acted on by the provider, which included setting up an assembly point in the front yard and verifying where the gas shut off valve was.

There were regular checks of the water system for legionella, and no disused outlets. Staff carried out monthly checks on water temperatures in sinks, showers and baths, with clear guidelines for staff on what was a safe temperature, records showed that these checks were satisfactory. Night staff carried out checks of the building's security and safety and carried out hourly checks on people who used the service when required.

There was a dedicated sink for handwashing in the kitchen, and a system of colour coded mops and chopping boards to prevent cross-contamination. We saw that food was stored appropriately in fridges and freezers, including labelling containers with the date they were opened. Staff took daily records of fridge and freezer temperatures and there were clear guidelines for staff on what constituted safe temperatures.

Plans indicated when people were supported to manage their finances, and what steps were taken to protect people from loss and financial abuse, these included storing cards and bank details securely and numbering receipts. When the provider stored money on behalf of people, the balances in tins were checked on a daily basis by staff and receipts were numbered and checked by the registered manager.

The provider maintained a CCTV system which covered the outside of the building, with clear signage indicating this was in use. In response to concerns about safety in the kitchen, there was a camera covering one area of the kitchen, but this did not extend to other communal areas. The provider told us that this was

to ensure that CCTV was not intrusive. There was a signing in book for visitors to the service and the front door was kept locked; where people were not subject to any restrictions on their liberty they had keys to the front door; we saw examples of people informing staff they were going out, this was recorded by staff. The provider told us that all people who used the service had keys to their own rooms.

People who used the service and their relatives told us that they thought there were enough staff to support people safely. Comments included "I've never seen it short of staff" and "there's always someone around". One professional told us "On balance they may be a bit stretched staff wise, but they're trying to manage some very challenging people." Care managers had recently commissioned an additional one to one worker to support one person during the day time as their health and behaviour had significantly deteriorated. Staff told us that this had made a big difference to their workloads. We checked three weeks of staffing rotas from the past two months, and saw that staffing was provided in line with what the provider had told us. This included having one waking night worker and one staff member sleeping in at night. Staff told us they carried a telephone handset at night which they could use to alert sleep in staff if required.

The provider had measures in place to ensure that staff were suitable for their roles. This included obtaining proof of identification and the right to work from staff, obtaining two references from previous employers and carrying out a check with the Disclosure and Barring Service (DBS) before staff started work. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions.

Relatives and professionals we spoke with were satisfied that medicines were safely managed. A professional told us "One person is covertly non-compliant, they've dealt with problems very well." We saw that medicines were kept in a locked cupboard in the main staff office, with excess stocks kept in a locked storage room upstairs. There was a fridge for storing insulin, with temperatures of the fridge and storage areas checked daily, with clear guidelines for staff on what were suitable temperatures. There was also a sharps bin for disposing of used needles. We saw that bottles of medicines were labelled with the date they were opened, and records were maintained of stocks of medicines which were stored in the service. Medicines were supplied by a pharmacist using the monitored dosage system. Medicines Recording Charts (MRCs) were appropriately completed by staff with no gaps in signing, and medicines were checked as part of the daily handover by staff. There were specimen signatures and initials for staff so that managers could easily identify who had administered a medicine.

At our last inspection we saw that there were not protocols in place for medicines which were given as needed (PRN). These were now in place, and clearly outlined when PRN medicines were to be given; staff had recorded when these were administered along with the reason why and the effect of the medicine. There were also application records for medicines applied topically such as skin creams, these gave clear instructions for staff, including areas of the body where these were to be applied.

Staff had received training in medicines administration, and managers had carried out checks to ensure that staff were competent to do so. We observed two people being supported by staff to take their medicines. This was carried out by two staff, with clear instructions and water given to the person. Where appropriate, staff checked that the person had swallowed their medicines.

A pharmacy advice visit took place yearly, the most recent having been carried out in January 2017. This showed no major issues of concerns, and where the pharmacist had made recommendations, such as to check stocks daily and for staff to countersign handwritten entries to the medicines chart, this had taken place.

Good

Is the service effective?

Our findings

Staff received appropriate levels of supervision and training to carry out their roles. Staff we spoke with told us that they received enough training, although some staff stated they would prefer more face to face training, as the majority of courses were provided online. Staff told is they would feel comfortable asking for more training as needed.

The provider maintained a system for ensuring that staff had received mandatory training, and this highlighted when staff were due to receive refresher training. This included training in first aid, food hygiene, person centred care, equality and diversity, record keeping, risk assessment and challenging behaviour. Staff had received training in line with the provider's training policy, this stated that mandatory training was carried out in line with legal requirements but did not fully assess the training needs for the service. The majority of the staff team had recognised national qualifications in care, and the managers were working towards a National Vocational Qualification for managers in care services.

On joining the service, staff underwent an induction, which was signed off when complete by managers. This included health and safety procedures, documentation concerning people who used the service and finance and missing persons policies. Staff then shadowed more experienced members of staff and carried out sleep-ins in the service before their induction was considered complete. Staff had monthly supervisions and an allocated supervisor. We saw that these were taking place as planned, and that supervision was used to discuss areas such as work planning, time management, well-being, performance management, health and safety, training needs, and how staff had applied this in practice. Supervision records appeared to accurately record conversations which had taken place, however in the month of February we saw that most staff supervisions were carried out in a different format, with significant use of stock phrases and duplication, which meant we couldn't be sure these were valid records. Staff we spoke with were happy with the support they received through supervision.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We saw that people had signed their care plans to document that they had consented to their care, and to abide by the rules of the house.

In some cases people had restrictions on their movements such as the ability to leave the house without support, for example due to concerns about people's road safety. Where this was the case, the provider had applied to the local authority in line with DoLS and informed the Care Quality Commission that they had done this. As part of the DoLS application they had assessed people's capacity to understand the risks from

going out independently. Where people were able to leave the service independently, they had keys to the front door and informed staff before going out. Most people who used the service were under restrictions such as informal or formal admission under the Mental Health Act or court orders, these were clearly documented in people's care plans. A staff member told us "We speak to people regularly about their restrictions, the teams they work with give them reminders too."

The provider told us that nobody who used the service was at risk of malnutrition, and we saw that people's weights were monitored monthly, so that staff would be aware if there were significant changes in people's weights. We saw that a menu was displayed in the kitchen, and people were supported to carry out their own shopping and store their food separately, including in locked individual food cupboards and in designated areas of the fridge. We saw that there were suitable amounts of fresh fruit and vegetables available.

Plans contained detailed information of the support people required with their health, this included people's dietary needs and health diagnosis. There were health action plans in place which were updated regularly and documented regular health checks including GP check-ups, eye tests and dentistry and the dates these were next due. Where people had diagnosed conditions, there was information on the treatment they were receiving and when follow up appointments were due. Progress reports were used to document how people's health needs had changed, and when concerns were identified by staff medical treatment was sought.

In response to comments from people who used the service and staff, the provider had built a smoking shelter which was further from the main building and protected people in the building from second hand smoke. There was evidence that people had been offered support to reduce or stop smoking, and in some cases this had been effective.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that they found the staff team caring and approachable. Comments included "It's very nice, it's very cosy", "I think the care is quite good there", "All the staff are approachable" and "They're helpful with talking and explaining what's happened in the past."

The service benefitted from a low turnover of staff and did not use agency staff. This meant there was a small and consistent staff team in place who people knew well. We observed friendly interactions, joking and chatting between people who used the service and staff, and observed people approaching the registered manager and deputy manager to talk to them and ask them questions. Where people appeared upset or distressed, we observed staff intervening to offer support and reassurance and to determine if there was something the person wanted. The registered manager told us that although people may not have chosen to live at the service "It's a good opportunity to look after them."

Each person who used the service had an allocated keyworker, and keyworking meetings were used to discuss people's needs. Topics discussed at keyworker meetings included mental and physical health issues, activities, living skills and money management. People's views were sought on day trips and the arrangements for going on holiday. People also discussed the house rules, which were clearly set out in a contract when people came to the service, and how recent incidents in the service had affected them. There was evidence that when people had not attended the residents' meetings, the provider had approached them after the meeting to ascertain their views. People had been consulted on drawing up a rota for using the kitchen and the laundry facilities. The provider told us that this gave structure to people's weeks and having a rota in place prevented disputes. People we spoke with told us that they had access to advocacy services, and we could see evidence of advocates being contacted on people's care files.

People were supported to speak up through monthly residents' meetings. These were used to discuss issues relating to the house such as activities, meals and food. People were encouraged to give their views on the redecoration and refurbishment of the service, and we saw that the kitchen had been repainted in line with people's wishes. People told us that they had chosen the colours in their rooms and had chosen how to furnish these themselves. People were supported to keep their rooms clean and tidy.

Staff told us of the steps they took to promote people's dignity and privacy. One staff member told us "I think people are treated with respect here, for example we make sure we shut the doors before carrying out care." We observed staff knocking on people's doors and asking permission before entering. On several occasions we observed people entering the staff office to discuss concerns with staff, and care workers and managers asked people to shut the door before speaking in order to protect confidentiality. We saw that when people wanted to discuss the behaviour of other people who used the service staff offered reassurance, but made it clear they couldn't discuss the needs of other individuals. People's information was kept safe by storing this in a locked cupboard and locking office areas when not in use.

Requires Improvement

Is the service responsive?

Our findings

Support plans were in place for people and reviewed regularly. However, we found that plans did not contain information on people's wishes and preferences, for example plans did not routinely document people's preferred foods, mealtimes and preferences for the gender of staff who supported them with personal care, and whether these needs could be safely met by the service. We found that plans were lengthy documents, but a high proportion of people who used the service had difficulty reading or were not able to read at all. There was no use of easy read formats, simplified English or pictures. This meant that we couldn't be certain that people understood the contents of their plans or that their views were incorporated into these. The provider told us that they would sometimes draw pictures to communicate concepts to people with communication difficulties, but they did not have an organised system of communication tools in place such as communication passports.

This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection we made a recommendation about how the service documented people's changing needs and recovery, and we saw that the provider had acted on this. Plans documented people's needs including identifying how people and staff would score the person in areas such as mental and physical health, self-care, work and living skills, relationships and families, social support network and responsibilities. These plans were goal orientated, and the format was designed in a way to ensure that goals were specific, measureable and time limited. Plans documented people's strengths, solutions and possible problems in how people would achieve these goals. Plans also documented people's alleged and recorded offences and restrictions on their personal choices imposed by court orders or restrictions under the Mental Health Act.

We saw that plans also documented what support was required in areas of daily living including shopping, cooking, mobility and spirituality, and daily logs of support indicated that care was delivered in line with support plans, including documenting people's sleep, mental health and support they had received with personal care. Plans also indicated when people's support needs would fluctuate in line with their physical and mental health. Where a person's needs had changed significantly, the provider had worked with commissioners to support a person to return to the service after a stay in hospital, measures in place included an additional one to one staff member and nursing care provided by the local NHS trust.

People we spoke with were satisfied with their activities. Comments included "There's always something to do", "They put on activities" and "I have enough to do; I go to football and a cafe." A professional told us "They're doing all they can to engage him." We saw that each person had a weekly activity plan, which was displayed on a board in the lounge. The provider told us this was in place so that people did not forget what they were supposed to be doing. Activity plans included days when people were supported to carry out household tasks and go shopping. One person's plan stated that they enjoyed going out for lunch with staff, and logs showed that this was taking place. Other activities include going to college and going to local centres. One person had informed staff they enjoyed gardening, and the provider had bought plants and

started tending the garden with this person. There were regular trips out including bowling and going to the cinema, and the provider told us that people had recently returned from a trip to the seaside.

There were items provided to assist with activities, these included board games, books, a full size pool table in the lounge and a punching bag in the garden. We observed the registered manager playing pool with people who used the service, although many people chose to watch television rather than engage.

Most people we spoke with knew who to make a complaint to. Comments included "I've never had to complain, but I'd know who to talk to" and "If I'm worried about anything I'll ask them." The provider's complaints policy and complaint forms were provided in the lounge. Records showed that no formal complaints had been made to the provider. However, the provider's policy stated that written complaints should be investigated and recorded, but did not state that managers needed to record verbal complaints, even though people may not be able to put complaints into writing without staff support. This meant that it was not always clear whether people had complained in the past, or what action was taken in response to this.

We recommend the provider put measures in place for recording verbal complaints and their outcomes.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in October 2015 we found that the provider was not meeting legal requirements. This was because they were not notifying the Care Quality Commission when significant incidents had occurred.

At this inspection, we found the provider was now meeting this requirement. The registered manager maintained a log of incidents and accidents, and recorded when incidents had taken place that needed to be notified and had ensured that this had taken place. This included when applications were made to restrict people's liberty. The provider was also meeting its requirements to display ratings from the previous inspection. The requirement to display ratings on the provider's website did not apply as they did not have a website.

We saw that managers were visible in the service and maintained an open door policy. Managers we spoke with knew people who used the service well, and we saw many examples of people communicating with managers and approaching them if they had concerns. The registered manager's office was based in a shed at the end of the garden which had recently been constructed, they had done this to maintain confidentiality to ensure there was somewhere they could speak to people without being overheard. The registered manager added that they planned to install a window in the shed so that they could see through to the main house. The deputy manager was based full time within the house.

There were systems in place to monitor people's satisfaction with the service, this included supporting people to carry out a satisfaction survey which showed overall people were happy with the service. Comments from professionals and relatives included "On a good day they are good" and "They're good at getting in touch if there's a problem" and "I don't think there's much that could be better". Staff told us that they felt well supported by their managers and the provider.

Managers had implemented systems to ensure that tasks were carried out and that good communication was in place. This included a daily task to be read at handover, including the allocation of appointments and medicines and the completion of health and safety checks, reading the diary and communication book. Staff had signed to indicate they had read messages in the communication book.

A quarterly visit was carried out by a director from the provider, which was called a 'person in charge' visit. This visit was used to monitor staffing issues, checks of medicines, whether people were happy with their care, checks of finances, the environment, records and health and safety. The director checked that identified issues from their last visit were addressed on their return. The last visit had taken place in February 2017 and this stated that health action plans needed to be updated, and this had taken place. However, audit systems did not detect that risk assessments were generic and lacked up to date information on people's behavioural support needs.

We found that managers were receptive to our concerns, and acknowledged the need to develop behavioural support plans and accessible forms of communication.

Staff meetings were taking place monthly. These were well attended by the staff team, and were used to discuss areas such as service user issues, maintenance needs, outcomes from the person in charge visits, staff responsibilities, supervision and training. Staff received an annual appraisal, where they were required to reflect on areas of their jobs they felt they did well, areas they had difficulty with and obstacles to performing well. This was used to review staff training and set objectives for the coming year.

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 Care was not designed with a view to achieving service user's preferences, and people were not supported to participate in making decisions relating to care and treatment to the maximum extent possible. 9(3)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to mitigate risks to the health and safety of service users 12(2)(b)