Consensus Support Services Limited

Frinton House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Frinton House provides accommodation for up to six younger adults who have learning disabilities. There were six people living at the home at the time of our inspection. People's needs were varied, some displayed behaviours that challenged and a number were on the autism spectrum. People had complex communication needs and required staff who knew them well to meet their needs. Frinton House is owned by Consensus Support Services Limited who have a number of care homes nationally.

There was 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.

This comprehensive unannounced inspection took place on 28 January and 02 February 2016.

Good governance had not been maintained. Although there were systems and processes in place they had not been carried out effectively to ensure required improvements were made to the service. Audits by the registered provider had not been carried out in a timely manner and where they had been done the reports of these audits had not been sent to the home.

Areas of the home had been adapted to meet the needs of one person and although this had made a significant difference to this person, this, and some of the behaviours displayed by this person had a negative impact on some of the people at Frinton House. Whilst the registered manager had identified that the service was not able to continue to meet this person's needs without it impacting on others, there had been a delay in taking action to ensure that more appropriate accommodation could be found. At the time of our inspection this matter was beginning to be addressed.

There were safe procedures in place for the management of medicines. However, protocols for the use of medicines prescribed on an as required basis were not detailed and it was therefore unclear when these medicines should be administered.

Although individual risks assessments were carried out, when changes occurred to people's needs they were not always updated to ensure that people were safe and had all the equipment they needed to maintain their safety.

The registered manager and staff had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, had assessed that some restrictions were required and made referrals for authorisations. However, there was no documentation to demonstrate that the least restrictive option had been used.

Some people led very busy lives which included attending day centres, college courses in the evenings and they had regular opportunities for walking, shopping and eating out in cafes and restaurants. One person

was supported to attend church regularly. However, others had fewer opportunities for daily activities and records showed a strong emphasis on car rides and watching DVDs. It was not always clear what the purpose of outings were and there were no systems in place to monitor if people were happy with these outings.

Staff knew people's individual needs and were able to describe to us how to provide care to people that matched their assessed needs. However, we observed some care practices that did not demonstrate that people's dignity was always maintained or that a personalised service was provided.

People had access to healthcare professionals when they needed it. This included GP's, dentists and opticians.

People told us that they liked the food. Relatives also spoke positively of the food provided. One relative said that the, "Meals are top quality, wonderful." Systems were in place to ensure that there were sufficient quantities of fresh food available and the location of the home meant that additional shopping could be done to cater for people if they changed their mind about what was on the menu.

There were enough staff who had been appropriately recruited, to meet the needs of people. Staff were aware of how to recognise and report safeguarding concerns.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from the risk of harm.

Medicine procedures were not safe in relation to medicines needed on an as required basis for one person.

Although individual risks assessments were carried out, when changes occurred to people's needs they were not always updated to ensure that people were safe and had all the equipment they needed to maintain their safety.

Recruitment procedures were in place to ensure only suitable people worked at the home. There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager and staff had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware when restrictions were required. However, they did not always have systems in place to document the reasons why restrictions were needed and to demonstrate that the least restrictive option had been used.

Staff had access to a range of training to ensure that they met people's needs.

People were supported to access a range of health care professionals to help ensure that their general health was being maintained.

People's nutritional needs were met and people could routinely choose what
they ate and drank.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always promoted.

Staff ensured that people looked well-presented and wore clothes that reflected individual tastes.

Staff communicated clearly with people in a way they could understand and it was evident that staff knew people well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people had opportunities to engage in meaningful hobbies or activities related to their interests. However, for others it was not always evident that they were supported to take part in social activities that were based on their needs and wishes.

Support plans included detailed information about people's needs and how they were to be supported.

There was a detailed complaint procedure in place along with an easy read version.

Is the service well-led?

Inadequate

The service was not well-led.

Systems for monitoring and improving the service had not always been effective.

There were mixed views about the management of the home. Some staff felt that they were not listened to whilst others told us the manager was supportive and approachable.

Information was available regarding 'duty of candour' and the registered manager was able to tell us how this would be followed if required.

Frinton House

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 28 January and 02 February 2016 and was unannounced.

When planning the inspection visit we took account of the size of the service and that some people at the home could find visitors unsettling. As a result, this inspection was carried out by an inspector without an expert by experience or specialist advisor. Experts by experience are people who have direct experience of using health and social care services.

During the inspection we reviewed the records of the home. This included staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises. We also looked at three people's support plans and risk assessments along with other relevant documentation to support our findings.

During the inspection, we spoke with four staff members including the manager and team leader. Following the inspection we contacted three relatives and received feedback from them on the running of the home. In addition, we requested feedback from professionals who had contact with people living at Frinton House, but we did not receive any feedback.

We met with people who lived at Frinton House. We observed the support which was delivered in communal areas to get a view of care and support provided across all areas. People used various methods of communicating with staff and we spent time sitting and observing people in areas throughout the home and were able to see the interactions between people and staff. This helped us understand the experience of people living at Frinton House.

Inadequate

Is the service safe?

Our findings

Staff had conflicting views as to whether people felt safe in the home. Staff told us that some people showed signs at times that they did not feel safe, such as leaving an area or getting agitated. People who could communicate verbally told us that they felt safe. Whilst staff worked hard to ensure people's individual safety there were times when this was not the case.

Risks to people were identified and plans put in place to manage the risks whilst protecting people's freedom and maintaining their independence. However, one person displayed behaviours that could sometimes cause harm to them and others. Action was taken to provide padding on their walls and bed to prevent them causing serious injury. However, there was no risk assessment to determine if this was the most appropriate action to reduce the risks of injuries occurring.

In addition to adapting the person's bedroom the lounge area had also been adapted to make this a safe environment for the person. For example, the television had been repositioned to make it less accessible. We asked if this person's behaviours had any impact on other people living in the home. We were told that one person flinched every time this person passed them and that they started to hum and then left an area if they felt unsafe. We were told that others tolerated the behaviours, but that one person laughed at times and tried to copy some of the behaviours. Whilst there was a chart recording all the person's behaviours there was no system in place to monitor the impact of their behaviours on others. The manager told us that whilst they felt they were meeting the person's needs and that the person had made very good progress since coming to the home, they were concerned about the impact on others. They said that they were working with the funding authority to seek alternative accommodation, but it was not clear at the time of inspection when this would take place.

Within one person's care documentation there was a statement that the person, 'struggles to get out of the bath, which will need to change, when the manager agrees.' Whilst there was a moving and handling risk assessment that stated that one staff member was needed to support them in/out of the bath, there was no specific risk assessment detailing how this should be done and highlighting any particular difficulties. Within the maintenance book there was reference to the need for a handrail, but this had not yet been fitted. Staff told us that they did not have any difficulty supporting this person in/out of the bath. The manager was aware of the request for the handrail but had not read the entry in the care documentation and was not aware of any specific difficulties supporting this individual. She confirmed that this would be reassessed to ensure that the person was supported safely.

We noted that on the daily health and safety rota, there was an 'x' beside a check on an epilepsy monitor in one bedroom. Staff told us that the monitor had been broken for some time. We checked the maintenance record and could not find that the matter had been reported for repair. The manager told us that they were not aware that the monitor was broken. This meant that if the person suffered a seizure at night, they might not be able to get the support they required.

One person had a protocol in place for use of a medicine, as required, in certain situations. Staff were able to

tell us the strategies they would take before they would administer the medicine. However, the protocol did not state the strategies to be followed and it was not evident on the medication administration record that the steps had always been followed. For example, staff administered a mild pain killer in the first instance and if this had no effect they administered stronger medicine. The medicine administration record (MAR) did not always show that the pain killer had been given in the first instance. As a result the person could have been over sedated when all that was required was a mild pain killer.

The above issues meant that people's safety and welfare had not been maintained. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection medicines were stored and recorded safely. There were safe systems in place for disposal of medicines and all medicines taken from and returned to the home as part of people's social leave were clearly recorded. Medicines were given at times people required them. There was a list of homely remedies in use and this had been agreed with people's GPs. (Homely remedies are medicines that do not require a prescription.)

All staff received training on the administration of medicines. In addition, they completed medicine competency quizzes and assessments annually to ensure that they followed correct procedures when giving medicines to people.

Regular health and safety checks were in place and they included infection control and cleaning checks, window restrictors, gas and electrical servicing and portable appliance testing. All staff had received fire safety training and people had personal emergency evacuation plans. They contained information to ensure staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency evacuation. There were regular fire safety checks in place including fire drills and staff were clear about what they should do in the event of a fire. However, new staff had yet to take part in a fire drill.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and evidence that a Disclosure and Barring System (police) check had been carried out, in addition to other required documentation.

There were sufficient staff numbers working in the service to meet people's needs. There were clear on call arrangements for evening and weekends and staff knew who to call in an emergency. One person required 14 hours one to one support throughout the day and an additional four hours for activities outside of the home. One other person also had a set number of one to one hours each week. There were enough staff on duty to ensure this level of support was maintained and we saw that this was consistently provided.

Staff knew what actions to take to protect people if they believed they were at risk of abuse. Staff told us they had received training on safeguarding adults. They told us about different types of abuse and what actions they would take if they thought someone was at risk. This included speaking to the manager or other senior staff within the organisation. We asked staff if they knew how to report concerns to appropriate external organisations. They told us they could report to the local authority or CQC.

Requires Improvement

Is the service effective?

Our findings

Staff understood how to meet people's needs and had the knowledge and skills to look after them. A relative told us that, "Meals are top quality, wonderful." One person told us that they decided menus at the resident's meetings. They said that they liked the food at Frinton House. Despite the positive comments there were times when care provided was not always effective.

The Care Quality Commission has a legal duty to monitor activity under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm.

Staff had received training on MCA and DoLS and were able to describe its principles and some of the areas that may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making.

There was a DoLS authorisation in place for one person and their support plan clearly stated why this was in place. Referrals had also been made for others and the registered manager was awaiting further contact from the Local Authority regarding the outcome. We were told that the main reason there was a need to have a DoLS in place was that the front door was kept locked. However, there were no individual risk assessments in support plans to assess if there were specific risks for individuals and to determine if the keypad lock was the least restrictive practice that could be used.

One person received staff support weekly to buy a ticket that occasionally gave them a financial reward. There was a risk assessment in place to consider all risks associated and to minimise the risk of abuse. It was clearly stated that the person had no understanding of their finances and staff told us that they restricted spending on the winnings as the person would spend all their money on tickets, if allowed. No formal capacity assessment had been carried out and the home had not considered if restricting the person's choice to spend their money was a deprivation of their liberty.

One person displayed behaviours that could sometimes cause harm to them and others. The home had taken action to adapt their bedroom to ensure that the area was a safe environment. However, they had not carried out a risk assessment to assess the risks and to determine the most appropriate action to reduce the risks. No capacity assessment had been carried out to determine if the person understood and agreed with the changes and no best interest meeting was held. Whilst it was clearly in the person's best interest to live in a safe environment the action taken could have been perceived as restrictive.

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

Staff received ongoing training and support, which included a mixture of online training and attendance at

external training courses. The systems for recording staff training were colour coded to highlight when training was due. Sixteen of the eighteen staff members had not received training on dignity, respect and person centred care.

Staff told us they received training which included safeguarding, infection control and food hygiene. In addition, they received training specific to understanding the needs of the people living at Frinton House. For example, staff received training on autism and how to support people and meet their individual needs. All staff completed training on epilepsy and how to support a person during a seizure. In addition, they did training on positive behavioural support which is training that teaches staff to understand the context and meaning of behaviours and to develop skills that can enhance a person's quality of life. Staff were able to tell us people's known triggers and the actions they took when these were shown. For example, if one person started to hum they knew that they were anxious and tried to identify why this could be the case and if they were unsure they offered a cup of tea or an alternative activity.

Staff received regular supervision which was booked in advance; they told us they were able to have extra supervision if they required further support. Some staff said that they found supervision meetings useful and that their supervisors were approachable. One staff member told us that they were trialling a change in venue for supervisions as they wanted to ensure that staff had the opportunity to relax and feel comfortable raising any issues they wanted.

Menus were decided on a weekly basis at the resident's meeting. We were told that the home did grocery shopping twice a week so that they could be spontaneous with meal choices. In between these times they were close enough to shops to be able to accommodate people's wishes. Those who chose to participate in cooking took turns to choose, buy, prepare and cook the main meal for everybody. People's participation varied depending on ability. For example, this could include observing meal preparation or active participation in peeling vegetables or stirring food. People were involved in choosing and where appropriate, making their own drinks.

One person had particular cultural food preferences and it was evident that there were ample opportunities throughout the week for their preferences to be met. We were told that whenever one person had their cultural food preferences they were careful to offer the same choice to another person who also liked this food. People were weighed monthly. Some people had a stable weight and there was an assessed need to monitor other people's weights.

Everybody had a health action plan. These identified the health professionals involved in their care, for example the GP and dentist. They contained important information about the person should there be a need to go to hospital. People attended a range of health care appointments to meet their individual needs.

The home had a chart to record one person's epilepsy. There was a code used to describe various seizure types. The chart referred the reader to the support plan to explain the code but there was no explanation of the code in the support plan. We asked a member of staff to explain the code but they were unsure of some of the codes. Whilst the support plan and risk assessment did not have information about the typical seizures experienced by this person there was a separate seizure record chart and this included a detailed description of the seizures experienced by the person. We recommend that the registered provider ensures that that guidance is consistent in all documentation so that staff are clear on what to expect should this person experience a seizure.

Requires Improvement

Is the service caring?

Our findings

Staff told us that people's privacy and dignity was respected. They said they knocked on people's doors and waited for a response before they entered the room. They told us they maintained people's privacy and dignity by always ensuring doors were closed when personal care was given and not talking about someone's personal habits in front of others. Despite this we observed some practices that were not caring.

In a communal area we observed a staff member calling out to another staff member asking them to check on a person's continence. This approach did not respect the person's right to privacy or take their dignity into account. This is an area that requires improvement.

Within one person's daily record there was a statement that the person had a 'tantrum when they got back' from their college. This was not an appropriate way to record that someone was upset. In addition, it was noted that there was no incident record and no record that staff had tried to identify why the incident had occurred and no record of how the situation had been dealt with. The manager told us that they had not been made aware of the incident. This is an area that requires improvement.

We observed one person deciding what they did during the day. We saw that two people preferred to have blankets rather than a duvet at night and this was respected. People's bedrooms were decorated in their own style and furnished with people's own photographs and ornaments. One person was involved in a local art group and various pieces of their work was displayed both within their bedroom and in some of the communal areas.

One person liked sensory equipment. During the inspection sensory equipment that had been ordered previously arrived by post. The person showed obvious delight in the new equipment and it was also noted that the person's keyworker took great pleasure in supporting the person to use the new equipment.

People were supported to dress according to their individual tastes. They looked well-presented and well cared for. We saw that when clothes were no longer clean staff noted this and supported people to change them.

A relative told us that they were very happy with how the home cared for their relative. One suggestion was made that, "Photos and names of staff are displayed so that visitors know to whom they are talking." Another relative told us that, "This is the best home X has ever had in their life." They said that they, "Get on well with all the staff," and said that staff kept them up to date whenever there were any changes.

Staff communicated effectively with people. We observed staff chatting with people throughout the day. Where people were unable to communicate verbally, staff were able to communicate in a way that met their needs. For example, when one person approached us and used a Makaton sign for 'sandwich', a staff member asked the person if they wanted a sandwich and the person followed the staff member to the kitchen. Makaton is a language programme which uses signs and symbols to help people to communicate.

One person used phonetic sounds to make their needs known. These sounds were clearly documented in their care plan. We saw that staff were able to identify these sounds and were able to meet the person's needs. Another person communicated well but some responses to questions were slow. Staff gave the person plenty of time to respond and did not try to guess what the person might have been going to say.

People chose where they spent their time and if they wanted to be on their own or with others. For example, one person liked to spend time in their room pacing. They had a large bedroom with plenty of space to enable them to carry out this activity. Another person had a sofa in the hallway and they enjoyed spending time there.

Requires Improvement

Is the service responsive?

Our findings

A relative told us that there were a good range of activities. They said that their relative had, "The chance to do so many things I've never been able to do." Another relative also told us that they were "Very happy with the activities." One person told us that they liked to keep busy and were happy with how they spent their days. Alongside these positive comments we received conflicting comments and we found that some people led busy and active lives whilst others had fewer opportunities to participate in activities that met their needs.

A staff member told us that one service user used to go swimming and they had enjoyed this activity but this had stopped. Another staff member said they didn't know why it had stopped. We were told that some people used to go to the cinema and liked it but that they were not taken very often. People were not always supported to have their social needs and preferences met.

One person's activity plan was not realistic as the person required two staff for all activities outside of the home. Some days the plan showed external activities in the mornings, afternoons and evenings but as there was only additional staff on duty in the mornings to support these activities the activities in the afternoons and evenings did not happen. Staff told us that the plan was just a guide.

One person liked to have car rides and we saw that regular opportunities were arranged for this to happen. It was noted that other residents were also given the opportunity to participate in these activities. Following one trip we asked the staff member where they had taken people. They had taken people for a drive to a particular village, but as it was dark they had not got out of the car. On the second day of our inspection, we asked a staff member who had returned from a trip where they had been. The purpose of the trip had been to take one person to a hospital appointment but another two people had gone along for the drive. We asked if they had used the trip as an opportunity to have a walk or to go to a café. We were told no, as they did not have any money and had not taken a wheelchair for one of the people. Whilst it is accepted that some activities are arranged spontaneously it was noted that for some people there was a lot of emphasis on car trips. Destinations were rarely recorded so people could have been taken to the same place every day and some would not have been able to say that this was the case. There was a lack of planning for meeting some people's social needs to ensure they were provided with opportunities for meaningful activities. This meant that staff were not working in a person centred way.

There was a choices and preferences chart in place to gain people's views. However, some people were not able to contribute to this process. Forms had not been adapted to enable everyone to participate so staff completed the form for some people. In one person's support plan it stated that they had preferences in relation to what time they wished to get up and go to bed, but the preference was not recorded on the form. This meant only staff who knew people well could ensure that their individual needs and wishes were met.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Alternatively some people led busy lives and attended college courses during the day and some evenings. One person attended an art class and another person liked walking. We saw that they were given regular opportunities to do this. One person was supported to attend church each Sunday. On the day of our inspection one person was taken to the library where they took out a cookery book. On the second day of our inspection they told us that staff had helped them to make cakes using a recipe from the book. We were told that annual holidays were arranged and that those who could choose destinations were enabled to make a choice about where they wanted to go.

With the exception of one bedroom which had been adapted to meet the specific needs of the person, bedrooms had been personalised and reflected people's individual tastes and wishes. Apart from the lounge area all other communal areas were also homely. Some furniture and pictures had been removed from the lounge area to meet one person's needs but this meant that the area was bare and had an institutional feel. We were told that one person was unable to have their cushions on their sofa. We were told that another person who liked to do an activity in the lounge now had to do this activity in their bedroom so that they would not be disturbed. This person told us that this was "a nuiscence." One relative told us that it was a shame that the lounge had changed and was less homely but they understood the reasons why. Another said, It is bare, the TV is not conveniently located but the bedroom is wonderful. The manager told us that they were aiming to redecorate the lounge and to gradually reintroduce furniture and fittings to make the area more homely. This is an area that requires improvement.

There was a complaint's policy in place and an easy read version was also available. People were regularly asked if they were happy or if there was anything they would like to do differently. There were no complaints recorded. Staff were able to tell us some of the signs people who could not communicate verbally would use to indicate that they were unhappy but there was no formal system in place to record how people with limited communications skills could raise concerns. This is an area that requires improvement.

There was a one page profile completed in respect of each individual and this was displayed in the office. This gave staff 'at a glance' information about the key needs of the individual and included a photograph of the person, what was important to them, information about what people appreciated about the person and how best to support them.

Staff had a good understanding of the support people needed and this and important information about people's lives had been recorded in their support plans. We saw in keyworker notes that a staff member had read updates in a care plan to a person. The support plans contained detailed information and guidance about people's routines, goals and training plans. There was guidance to ensure staff knew how to support people if they displayed behaviours that may challenge others. In addition, where people had autism, there was specific advice on autism might affect their day to day life.

Inadequate

Is the service well-led?

Our findings

A relative told us that the home was well run. They said that the manager was, "100% and it's all lovely." Another relative told us that the manager kept them fully informed of their relative's needs and any changes to their wellbeing. Despite these positive comments, we found that at times the home was not always well led.

We discussed with the registered manager the changes made to the environment and the impact this had on others living in the home. The registered manager confirmed that alternative accommodation was now being sought for one person, as although the person had made significant progress since moving to the home, they had to balance the needs of one person versus the impact this had on other people. They acknowledged that because this person had made such progress and because a number of the staff team felt they were able to support the person, this had delayed the decision for action to be taken. Whilst it was evident that the provider was now assisting the registered manager to support the person to move to more appropriate accommodation, it was not evident that the support system for the registered manager had been in place for several months.

The provider had systems to monitor the management and quality of the home. This involved monthly unannounced visits from an external manager who carried out a report on their findings. We saw that visits had been carried out monthly up until July 2015. We were told that a visit had been carried out in October 2015 but the registered manager had not received a copy of the findings to enable them to make any improvements required. We were told that a new operation's manager had been appointed and had just started in post. They had already carried out an audit of the home and attended a staff meeting the previous week. The registered manager had not yet received a copy of the findings of the audit. Whilst the registered manager felt supported and said that there was always someone available if they needed to talk about an issue, records did not demonstrate that the registered provider effectively monitored the delivery of the service.

We received mixed views about the management of the home and whether staff views were listened to. One staff member told us that the registered manager was a good leader. They said that they felt comfortable challenging them if they had a different opinion on a matter, and that they listened. For example, they had asked the registered manager if they could give staff advance notice in writing of meetings, this had been agreed and the result had been an increase in attendance at staff meetings. Another staff member told us that when they needed specific support to ensure they could do their work effectively, the manager had gone out of her way to ensure that they had the appropriate equipment to make this easier. However, another staff member said that they did not always feel listened to. They said that they tried to raise issues through supervision but felt that things did not change. In daily records, the tone of some records indicated frustration, 'This has been reported several times and nothing done about it.' At the last staff survey, in response to a question about being recognised for the work they did, five staff said they were always recognised, seven staff said they were sometimes recognised and one person felt they were never recognised.

Records showed one person's weight had increased by 12Kgs in six months. Another person had lost 4Kgs in the same time period. A third person's weight fluctuated. One person had a soft diet and if their weight decreased supplements were given. We were told that a dietician monitored this person's weight periodically. When we discussed the recordings relating to the increase in weight staff they said that this must have been a mistake as the person had not visually gained any weight. Whilst staff had no concerns about this person's weight it had not been picked up that either there was a staff error in recordings or the scales were not working.

The daily shift form detailed which staff members had responsibility for various tasks. For example, who dealt with medicines, health and safety, driver duties and who provided support to each person. All appointments were listed and people's activities were also recorded. Some people had busy days with lots of structured activities whilst others had less structured activities and there was a strong emphasis on car rides or watching films. Records did not show where people went or what films they watched. There was no monitoring system to analyse what people gained from the less structured activities or to check if they were doing the same car ride each time or watching the same films over and over.

A service user survey was carried out in June 2015, the responses were collated and this showed that the home achieved a score of 95%. The survey showed that all service users had participated in the process. However, when we spoke with staff it was clear that not everyone would have been able to participate in the process. There was only one format in place to seek views. Records did not demonstrate what feedback had been given to people about the requests that had been made as part of the survey. This did not demonstrate that people were listened to.

As part of the staff recruitment process we noted that on one occasion, one person was recorded as having been involved in the interview process. However, notes did not include reference to how the person was involved or what their view was of the applicant. This did not demonstrate that the person's views had been listened to and considered as part of this process.

Residents meetings were generally monthly although it was noted that there were no minutes of meetings from July to December. Minutes were repetitive and often said that people didn't have anything to say. There was no record of questions asked to encourage people to share their views. We discussed this with staff and they said they would look to change the format of meeting to try to encourage greater participation.

The registered provider did not operate effective systems to assess, monitor and improve the quality of services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unable to tell us about the organisation's vision and values. This meant that the registered manager could not be sure that staff understood and worked to the values of the service. The provider sent the home copies of minutes of meetings held at head office. Within these minutes there was guidance to ensure that the organisation's vision and values should be discussed at staff meetings and that a poster should be displayed outlining them. We asked a staff member if there was a poster on display but they could not find this. On the second day of our inspection we asked the manager about the poster and were shown that there were two posters displayed in the manager's office. The manager confirmed that a special effort had been made to go through the organisation's vision and values with staff and she was disappointed that staff had not taken this on board. She stated that this would be highlighted again at the next staff meeting.

There were good systems in place to ensure that the registered manager notified the provider of all changes

or when events occurred such as, incidents and accidents, staff hours, staff supervisions and training. The system updated statistics automatically and produced graphs showing how the home was performing. The registered manager had support form a positive behaviour team to assist with drawing up guidelines for people who had behaviours that challenged.

Notifications had been completed when required. The registered manager displayed a good knowledge of when and how notifications to CQC or other outside organisations were required. Information was available regarding 'duty of candour' and the registered manager was able to tell us how this would be followed and actions that would be required to ensure the organisation was open and transparent.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that people received care and support in line with their individual needs and wishes. 9(1)(3)(a)(f)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that where people lacked capacity to make informed decisions the care and treatment was provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. 11(1)(3).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured peoples safety and welfare at all times. 12 (1)(2) (a)(b)(d)(g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

The provider did not have systems in place to assess, monitor or improve the quality of services provided.

17 (1)(2)(1)(a)(b)(e)(f)

The enforcement action we took:

Warning notice