Optalis Limited

16 Homeside Close

Inspection report

16 Homeside Close
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Berkshire
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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

16 Homeside Close is a care home without nursing and provides accommodation and support to adults with learning disabilities or autism. The care home is located within a residential area of Maidenhead, Berkshire. There are two floors. On the ground floor are communal areas, kitchen and laundry and some people's bedrooms. The first floor has more people's bedrooms, communal bathrooms and a staff office. In accordance with the current registration, the care home can accommodate up to eight adults. At the time of our inspection eight people lived at 16 Homeside Close.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always safe from risks related to the building. Although a comprehensive range of checks were conducted for health and safety risks, the reports were often not noted or acted on by the provider. Remedial actions, such as repairs, were not communicated, planned or completed. We found a number of instances where important repairs or changes to the premises were missed.

People's care risks were assessed by staff and recorded within their care documentation. Care risks were not always appropriately recorded or reviewed and required improvement.

There were long standing vacancies of permanent care workers. The provider had no underlying system to calculate what a safe number of staff to deploy was. Staff routinely worked overtime, cancelled their annual leave or dedicated training and there was ongoing use of agency workers.

Medicines were managed safely, but some improvements were required to ensure robust systems were in place.

The service required some improvements with staff training, supervision and performance appraisals. These were sometimes not completed or overdue. Consent and ability to make decisions was recorded in people's care plans, although there was some conflicting information. People had good provision of food and drinks. People's care was supported by healthcare professionals from the local area.

Some areas of the premises, like the communal bathrooms, were refurbished to a high standard. These helped people complete daily hygiene and encouraged their independence in the process. Attention was required on areas which were a risk to people, such as the first floor carpet and external paving. The kitchen, although clean, required redecoration.

Staff were kind and caring. They knew people's likes, dislikes and preferences well. Staff respected people's privacy and dignity. Staff told us they enjoyed supporting the people who used the service.

Care plans were in place for people, but contained outdated information. Care plans also conflicted with each other in some cases. There was a complaints procedure in place, and feedback was sought from relatives. No feedback was captured from people or community healthcare workers.

The provider's systems of measuring the safety and quality of care were not robust. Processes for care quality management since the change of registration in 2017 were not in place. Audits and checks that were completed were not focused on driving continuous improvement. Best practice in caring for people with learning disabilities or autism were not considered or put into place.

Staff liked working at the service and told us there was a positive workplace culture. They felt the registered manager and deputy manager had supported them well. They felt more contact with the provider's senior management team would enable them to better understand the organisational expectations.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were safely managed, but required minor improvements to ensure best practice.

A system to determine safe staffing deployment was not in place.

Risks to people from the building and equipment were adequately assessed, but not always acted on.

People had risk assessments in place for their personal care, but these were sometimes not clear, reviewed or monitored.

People were protected from abuse and neglect.

Is the service effective?

Requires Improvement

The service was not always effective.

People received support from staff with good knowledge and skills but staff training, supervision meetings and performance appraisals were overdue.

Further redecoration of the premises was required.

People had access to appropriate multidisciplinary care teams to support and promote their ongoing health. Records for healthcare required better organisation to ensure clarity.

There was some conflicting information about consent but people's best interests were considered and as far as possible, they were included in important decision making.

People were protected from malnutrition and dehydration.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

People had developed positive relationships with staff that supported them.

People's privacy and dignity was protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's preferences for communication were recorded and staff used alternate methods of communicating with people.

Care plans were personalised.

Information in care plans was sometimes outdated, conflicting or incomplete.

A complaints process was in place, but required some improvement.

People's and stakeholders' views were not captures, but surveys were sent to and received from relatives. These showed complimentary feedback.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The safety and quality of people's care was not consistently checked, recorded or acted upon.

Policies, procedures and operational processes from the provider were not embedded in the day-to-day operation of the service.

There was a positive workplace culture and staff worked well together to support people.

16 Homeside 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 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.

Our inspection took place on 21 September 2017 and was unannounced.

Our inspection was completed by two adult social care inspectors.

This is our first inspection of the service since the change in provider.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public, local authorities, clinical commissioning groups (CCGs) and the fire inspectorate. We checked records held by Companies House, the Information Commissioner's Office (ICO) and the Food Standards Agency (FSA).

During our inspection we spoke with the registered manager, the deputy manager and three care workers.

We spoke with one person who used the service and observed the care of four other people. We looked at three medicines administration records and two sets of records related to people's individual care needs. This included care plans, risk assessments and daily monitoring notes. We also looked at one staff personnel file and records associated with the management of the service, including quality audits. We asked the registered manager to send further documents after the inspection and these were included as part of the evidence we used to compile our report.

We looked at the premises and observed care practices and people's interactions with staff during our inspection.

Requires Improvement

Is the service safe?

Our findings

People's medicines were ordered from a community pharmacy. These were dispensed to the service in blister packs. Some medicines not suitable for blister packs were dispensed in boxes and bottles. Medicines were correctly locked away and accessed by using keys. There was a list of staff with specimen signatures that could hold the keys. We checked the receipt, storage, destruction and return of unused medicines to the pharmacy and these were satisfactory. The administration and recording of medicines was appropriate and staff counted stock and counter-signed to ensure people were safe from medicines incidents. A new thermometer was required for the medicines fridge so accurate minimum and maximum temperatures could be recorded. All staff who worked at the service could administer medicines. Training and competency assessments for medicines were required annually, but the registered manager explained that these were not completed since 2016 and now out-of-date. We noted that there was a 'homely remedies' policy dated 23 January 2016. 'Homely remedies' are medicines that can be purchased over the counter to take for minor ailments, like headaches. People were prescribed paracetamol for 'as required' use and staff used the 'homely remedies' to provide this. The community pharmacist completed an audit on 12 September 2017 and reported some actions required by the service to ensure the safe management of medicines.

One person's care plan showed they were prescribed a certain medicine. There was no further information on file to explain what the medicine was used for. When we spoke with the registered manager, they explained the medicine was prescribed for a specific health condition and agreed relevant information needed to be in place about the medicine.

The building was not owned by the provider and maintained by a housing association. We checked how the service managed risks to people from the premises and equipment. We found risk assessments were completed by contractors. However, the service did not have copies readily available and were not aware of the findings from some of the risk assessments. This meant they had not always contacted the housing association to complete any remedial actions noted in the building or equipment risk assessments. There was a fire risk assessment dated 26 June 2017 with a number of remedial actions required to ensure safety of anyone in the building. There was no record these were acted on. A Legionella risk assessment was completed on 26 October 2016 with 11 remedial actions required. A contractor had commenced the prevention of Legionella, and there was a folder on site for recording any checks completed. However, the contractor only signed to say they visited the premises and left no other information about the checks they completed. These were only provided to the housing association and the service had not obtained the records. Samples from May 2017 showed there was no Legionella present in the water at the time. A check of the passenger lift completed on 5 May 2017 demonstrated that four corrective actions were required, but required works were not requested by the service.

We recommend that the service develops a robust system to ensure risk assessments are obtained, retained and remedial actions are promptly acted on.

We found other risks from the building and premises were adequately mitigated to protect people. Window

restrictors were fitted to all first floor windows and checked weekly by staff. Gas safety was checked on 22 June 2017 and was compliant. Portable electrical equipment was checked and found to be safe. The building's electrical wiring was last checked in March 2014 and found to be "satisfactory". Periodic inspections of fixed wiring occur every five years. Staff checked hot water outlet temperatures weekly and recorded these. We saw the records showed the hot water was within the recommended range.

The calculation of staff deployment required improvement. We found there was no underlying system in place to determine a safe level of staff for any shift. We asked about the staffing pattern and found it was based solely on repetition of the same numbers of staff for morning, afternoon and night shifts. We looked at the staff rotas from 30 July to 21 October 2017. We saw there were long-term vacancies for care workers which were not filled and therefore shifts were regularly completed by agency workers. Permanent care workers did complete additional shifts to fill gaps in the rotas, and were paid overtime accordingly. However in some cases we saw this had resulted in cancellation of their scheduled rest days, annual leave and dedicated training. People who used the service were provided access to a local day centre each week, and staff accompanied them. Other people made visits to shops and cafes in the nearby community. Some people stayed in the building which meant at least one staff member remained at the service with them. The establishment of the staffing deployment did not provide ample staff for day trips further away from Maidenhead or holidays for people. When we asked staff, they told us they were "busy" but did not feel people were placed at risk of harm.

We recommend that the service develops a method of determining safe staff deployment.

No new staff had commenced at the service since registration under the current provider. The registered manager told us two applicants would be interviewed in the weeks after our inspection. We checked on existing personnel file and found it contained the necessary documents required by the applicable regulation and associated schedule. This included proof of the staff member's identity, a full job history, checks via the Disclosure and Barring Service (DBS) and references. We noted that the agency worker profile forms did not contain all the necessary information required. We pointed this out to the registered manager who told us they would contact the agency and ensure this was changed.

We saw risk assessments for people's personal care were in place in the two files we checked. We found the assessments identified the potential risks, positive and negative outcomes associated with those risks and actions to minimise the risk. The risk assessments showed they were tailored to each person's unique needs.

Risk assessment documentation was not regularly updated and conflicted with other information in people's care folders. One person's care folder identified risks in the areas of access safe use of vehicle (the service's van), bathing and showering, likelihood of responding to a fire alarm, accessing the kitchen and accessing the community. However, we saw no evidence of review or management of risk monitoring. Therefore it was not clear if the person's identified risks were still realistic, if the actions identified to minimise a risk had been applied or implemented by staff and if those actions had been effective in minimising the risk.

We saw one person's risk assessment for a wheelchair dated from 2009. When we discussed this with the registered manager, they confirmed that this was a historic document and the person had not used or needed a wheelchair for many years. We noted that information in other sections of the care file suggested the person needed support with their mobility. However the registered manager confirmed this information was also outdated and the person could mobilise independently. The information about the person's risks of mobilising no longer relevant and more accurate information was not recorded.

One person had a bowel chart because they occasionally became constipated. We saw there were ad hoc entries from July to September 2017. This was a standalone document with no information to explain its purpose. The risk of constipation was not clearly explained and why the bowel movements were sporadically recorded was unknown. We also a weight chart where the person's weight was meant to be recorded monthly. There were no entries for March, June, August or September 2017. The purpose or the charts were not clear, often missed completion by staff, were not monitored or reviewed.

People were protected against abuse and neglect. There was a safeguarding and whistleblowing policy from the provider, which was outdated and did not contain information about how to report events within the local authority area. The policy stated that local reporting arrangements were used. We noted the staff office had a poster displayed which provided the contact details for the adult safeguarding team. This included out of hours contact information. We saw staff had received safeguarding and whistleblowing training. When we spoke with staff, they were aware of the types of abuse and told us how they would act if they suspected someone was harmed or at risk. Our records showed there were no allegations of abuse or whistleblowers since the date of registration.

Requires Improvement

Is the service effective?

Our findings

We looked at staff knowledge, skills and experience which supported them to care for people who lived at 16 Homeside Close. We were shown the staff training matrix and noted the majority of the staff team had worked in the service for over ten years. This meant they had gained significant knowledge and experience about caring for people with learning disabilities. In addition, as people had lived at the service for a long time, staff used their knowledge about people to provide the best possible support. Records we viewed demonstrated that most staff had completed the provider's mandatory training.

Minor improvements were required. We noted the registered manager was booked to attend seven of the eight mandatory training courses between September and December 2017. This meant that their refresher training was not evenly spread out across the calendar year. Another staff member had last completed safeguarding training on 11 February 2015, but the provider's requirement was that this topic was completed every two years.

We looked at three staff supervision records. The registered manager stated that staff were expected to be offered and receive six supervision sessions each year. Since the registration of the provider we found one staff member had participated in two supervision meetings, but the notes could not be located at the service. Another staff member had two supervisions in 2017 but again the notes were not available at our inspection. The deputy manager had received their supervision sessions in line with the provider's expectations. One staff member, who we were told commenced in October 2016 had not completed any supervision sessions since April 2017. Appropriate numbers of support meetings were not conducted with all staff and records could not be located.

We looked at staff appraisals. The registered manager told us that all staff appraisals were overdue. We reviewed one staff appraisal from March 2017, but this was prior to the provider's registration and covered the 2016 development year. We were unable to look at any other examples of staff appraisals. We were told that the delay in appraisals was due to the change in provider. The registered manager stated that they had given all staff the new provider's appraisal form and would be carrying out all staff appraisals shortly. We were able to see written information to support this statement.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

We looked at the provider's policy about consent, MCA and DoLS. This was dated 6 May 2015 and due for

review on 6 May 2016. The policy contained all of the necessary information regarding the Act and associated codes of practice, but was not reviewed. This meant recent case law regarding the use of MCA and DoLS was not included or considered as part of the practice. People who used the service had lived at 16 Homeside Close for long periods of time. At the time of admission, there was a requirement to gain a person (or delegate's) consent to care. We looked at two people's care folders. One person was deemed to be able to make decisions themselves and the other person did not have capacity to do this. Within the two files we examined, we saw "consent to care and treatment" forms for personal care and health appointments completed 1 February 2017. It was not clear why the consent forms were completed at this time. There was no evidence that best-interest decisions were recorded for the person who could not make decisions because of their mental capacity.

We checked whether people had access to or used independent mental capacity advocates (IMCAs). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. The registered manager stated there were no advocates involved with people's care. Seven of the eight people residing in the home had family input. We saw that had no family involvement had an advocate, but they had not been in contact for many months. The service needed to ensure that regular communication with the IMCA enabled best interest decision-making.

Conflicting information regarding consent, mental capacity and the need for DoLS authorisation was found in one person's care documentation. Key information relevant to the person's care was overlooked or missed by the service's staff. We saw an annual placement review was completed by the local authority in April 2017. The local authority review recorded the need for a DoLS to be in place regarding accommodation and care as it was deemed they were subject to constant supervision and not free to leave. When we discussed this with staff, they had failed to note this conflicted with the information already in place which stated that DoLS not needed the person could make their own decisions. The staff told us the person had made a formal choice to reside at the service. The registered manager they would review this information and take action to resolve the conflicting information.

We also noted a letter from the Office of The Public Guardian dated April 2017 regarding whether the person had appointed a (power of) attorney or a court-appointed deputy. The letter confirmed there was no record of a registered attorney or deputy. However, after discussion with staff regarding the person's finances we were told this was managed by the deputyship team of the local authority. Again staff had not noted this letter had offered conflicting information. We raised this with the registered manager who told us they would review this and investigate further to gain the correct information about the person's finances.

We looked at the adaptation, design and decoration of the service. The building was suitable for people with learning disabilities. There was enough space between each person's bedroom on both floors to ensure there was privacy and noise levels were minimised. We saw there were large communal dining room and lounge areas. We observed some people liked to go to these areas, whilst others preferred their bedrooms. Accessibility was good to all areas of the service. There was a passenger lift or set of stairs for accessing the first floor. Flooring was even and corridors were wide, for anyone who used a mobility aid. A dedicated disabled parking bay was available at the front of the house. We noted that two bathrooms were completely refurbished and were suitably designed for people with mobility impairments. Staff told us the changes in the bathrooms had enabled people to be more independent and assisted them in the provision of daily personal care.

We noted paving at the rear of the service was uneven and paving stones presented a risk of trips and falls to

people and others. The carpet on the first floor corridor was threadbare in one place, which again increased the risk of falling from trips on the flooring. The kitchen was dated and in some parts difficult to clean.

We recommend that the service considers redecoration of the kitchen.

People received appropriate nutrition and hydration. Staff encouraged people to eat and drink and provided support, as needed. Meals were selected by people or by staff when their preferences were known. We checked the pantry, fridge and freezer and found that adequate supplies of fresh and frozen foods were available. Weekly shopping occurred for the service, but people were able to buy items on their trips outside into the community. There were pictures of foods that people could see and point to if they wanted to indicate their particular preference. Words underneath the pictures were required to state what the meal, food or drink were. The pattern of the menu was repetitive at times and more consideration of a healthy, balanced diet planning was necessary.

We saw from people's records that they were supported by healthcare professionals in the community. There was a mixture of professionals visiting people within the service, or staff escorting them to appointments in the area. Adequate records were kept of calls to and from healthcare professionals, although staff had not always obtained copies of important results or letters from the visits. Instead, information was written down on a form by staff. Some redundant, outdated information was in the healthcare professional section of the care folders. This could have been removed to ensure that only the latest, most relevant information about the person's health was available.

Good

Is the service caring?

Our findings

We spoke with one person who used the service. A staff member who knew the person well facilitated the communication with us. The person told us they had a burger with chips and coffee for lunch at the nearby day centre. When asked what they liked at 16 Homeside Close, they said, "Good food." They told us they were "happy" living at the service and they liked fruit and the car trips. Although the person liked to mainly sit on the floor in their room, the staff member told us the person was very mobile and able to manoeuvre around on their own. The staff member was able to provide a lot of detailed information to us; their likes, dislikes, preferences and what significance each item in their bedroom had to them.

As part of our inspection, we observed people's interactions with care workers and how care was provided in the dining room and communal lounges. We saw staff were consistently kind and caring. We observed staff were patient with people and took their time, for example when having their breakfast or getting into our out of the service's vehicle.

People had a meaningful social life, mainly within the local community. Each person had access to half day sessions at a nearby centre. The centre provided a vast array of activities and events for people with learning disabilities and autism. Staff stayed at the day centre with people when they visited. Alternatively, people could stay in the service and were free to either spend time in their own room or participate in suggested activities by staff. Although staff knew the types of activities people liked at the home, staff were sometimes busy completing other work and not able to sit or spend periods of time engaging with the person. People were safe, as staff were present at all times a person was at 16 Homeside Close. People also had regular trips into the local community, mainly to shops or cafes. Trips away, like holidays, occasionally occurred and staff accompanied people to support them.

During our inspection, we saw that staff supported people's privacy and dignity. Staff we spoke with told us they would speak with people and seek their consent before they commenced any care or support. We found people were appropriately dressed, addressed by their preferred names and we saw that the service supported people's independence as far as possible.

People's confidential personal records were protected. We saw all office computers used for recording information were password-protected and available only to staff with the appropriate access. Paper records of care were maintained, but where these existed they were locked away so that there was restricted access to staff only. Staff records or documents pertaining to the management of the service were also locked away. In some instances, where there was sensitive information, the records were only accessible by the registered manager or provider.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 (DPA) requires every organisation that processes personal information to register with the ICO unless they are exempt. This ensured people's confidential personal information was appropriately recorded, handled, destroyed and disclosed according to the legislation.

Requires Improvement

Is the service responsive?

Our findings

The service ensured that people had access to the information they needed in a way they could understand it and were compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place by the NHS from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We were told most staff could use Makaton; a type of sign language for people with learning disabilities. People's support plans also included information about how to effectively communicate with them. There was also some easy-read signage throughout the service and symbols or pictures were used in people's care folders.

We looked at two people's care documentation to check whether the support provided at 16 Homeside Close was personalised. We saw there was extensive information about each person. The folders however were disorganised and not set out in an easy way for staff to follow or find information quickly.

In the first person's file we saw a current photo and general information about their life story. We noted the person visited their sister and mother regularly. However, the contact details for the relatives had not been recorded. We asked the registered manager about this and they were unable to tell us why this was, but said they would find out and add these details. We found information regarding family visits was sparse despite these taking place three times a week. This was corroborated when we looked at the staff handover record found one short sentence was included. We saw there was a pen profile, which included information of personal preferences, interests and community involvement. There was limited written evidence to demonstrate community outings in line with the person's recorded preferences for crazy golf, bowling, music shows and bands.

We checked the person's care plans. Areas covered included personal care (washing and bathing), finances, activities and trips, behaviour, medicines and health. Care plans showed some person-centred information and included the person's likes, dislikes, personal history and individual health care needs. There was confusion about funding available for the person's holidays. Staff told us the person previously received £220 a year from the previous provider however were unsure whether this would continue with the new provider. Staff failed to clarify this, which meant they could not plan, book or take the person on holidays. This was ongoing from April 2017. The registered manager told us they would make a relevant enquiry to find out about the person's social spending.

Information in the person's care plan about death and dying recorded, "[Relatives] to guide arrangements", as staff felt the person might become upset if they discussed this directly with them. There was no recorded documentation about this type of discussion with the person's family. Staff had made an assumption that the person would either not understand the subject or become upset if they discussed this with them. No record was made as to how this decision-making occurred or who had decided this. We identified that this discussion needed to occur promptly as there may not be the ability to engage with the person's family in the future, and therefore unable to contribute to a decision.

The health section recorded that the person was assisted by hearing aids. We saw evidence the person had regular checks of their hearing; the last one occurring in July 2017. We did note that the staff entry from the person's hearing review stated, "Rewarded [the person] with two new boxes (of hearing aids) for being good." We had a discussion with the registered manager regarding the wording of this documentation. They had not noted this, but agreed that this was inappropriate stating it was the way it was written rather than a reflection on the attitude of staff, who they felt were always respectful to people using the service. The registered manager agreed to address the style of people's notes with all staff members.

When we looked at another person's care file, we found that some of the improvements identified in the first file we looked at were repeated. In the financial section of the file, staff had recorded rent was paid to the housing association via direct debit. Further handwritten notes we saw stated the person paid rent via the local post office. We checked with staff how the rent was paid. They confirmed the person's rent payment was via a post office transaction, with staff support. This was conflicting information. In addition, there was a document called "Guide to your tenancy agreement." However, there was no further information about this on file and it was not clear whether the person had a valid tenancy agreement. In the activities and trips out section of the file, the document stated the person liked theatre shows, visiting their mum and brother. Again, there was a lack of written evidence to support this. Information regarding family visits was sparse; we saw it was one short sentence in the staff handover record.

We checked what systems were in place at the service to routinely listen to and learn from people's experiences, concerns and complaints. The registered manager confirmed that no surveys with people who used the service were conducted since the change in registration. However, we saw the service convened weekly meetings with people. There was evidence of weekly meeting minutes, which we reviewed. We saw there was a standing agenda which covered menus, activities, staff issues, health and safety and complaints. Meetings were chaired and facilitated by staff, but people were able to raise topics or indicate their preferences and choices. We found the meeting minutes did not address any changes since the last meeting but we could identify any patterns of concern.

The registered manager stated relatives' meetings did not take place. This was because 16 Homeside Close is a small service and relatives were often in contact via telephone and by visiting their family member. The registered manager explained that there was little benefit in holding meetings as relatives were in frequent contact and could voice any concerns or provide feedback to staff, which they had developed good bonds with over time.

We looked at the findings from relatives' surveys. We saw evidence of annual relatives' surveys for 2017. The registered manager explained that questionnaires were posted to family members with a stamped addressed envelope to encourage and support completion or return. We viewed all seven returned surveys for 2017. We found all of the surveys recorded positive responses about the care of people. However, there was no evidence of evaluation and feedback to people, staff or the relatives themselves. The registered manager told us they would look at developing a formal evaluation and feedback process.

There were no complaints about the service since the registration commenced. The registered manager and deputy manager were aware of the management of complaints. However we did not see any signage within the service about how to raise concerns or make a complaint. For people, some basic pictures on a noticeboard showed how they could tell staff their feelings. There was a suggestion box, but it was unclear who the suggestion box was designed for and how it was used.

Requires Improvement

Is the service well-led?

Our findings

At the time of the visit, the registered manager was registered to manage two of the provider's services, both within a short distance of each other. At 16 Homeside Close, a deputy manager was also in post and able to help oversee the service in conjunction with the registered manager. At the registered manager's other service, the deputy manager had retired, meaning there was no backup from a senior staff member at that location. The home manager of another service under the provider's registration was on annual leave for two weeks, and the registered manager of 16 Homeside Close was expected to additionally oversee the third service. The registered manager was required to be on call for the services, deal with staff vacancies, cover and shift shortfalls, attend important meetings and events and ensure the safe operation of all three services. Although the registered manager had good support from their line manager, the concurrent management of three services over a short period was unsafe. We found other options were available from within the provider's own group of services that could have supported the short-term management of the third location.

The registered manager demonstrated a clear knowledge of their responsibilities and people's needs. However the systems in place to monitor and support the provision of care were not always clear. Changes between the providers of the service had resulted in confused operational systems at the service level, for example policies and procedures. The fundamental monitoring and evaluation of staff and systems remained unchanged and the new provider had not implemented their own systems in the service. We found limited written evidence and some gaps in knowledge regarding the tools for evaluating and improving the service.

We found multiple policies from the provider were not reviewed or out of date. The registered manager and deputy manager had appropriately printed the policies out and placed them in folders for staff to read. However, staff often were too busy providing support to people to read the policies, check for updates or understand the content and ask questions. We checked what systems the service used to monitor the safety and quality of the service. Despite registering in April 2017, these had not changed since the provider had taken operational responsibility for the service. Some were not fit for purpose, contained sparse information and where deficits were found, these were not actioned or carried forward for the next audit. This meant the information from audits and checks was not used to always drive continuous improvement.

The most comprehensive audit that occurred was titled "CQC evidence checklist" and usually completed monthly by another service's manager. We saw this was based on "outcomes 1 to 21", which were part of prior legislation we inspected under from 2010 to 2014. Some prompts from the new regulations, key lines of enquiry and key questions were missing. This meant new standards of safe and quality care were not incorporated in the tool. However, the audit did contain some subjects still relevant under current regulations. These included person-centred care, medicines, assessing and monitoring the quality of the service and equipment. We looked at the last audit dated 11 September 2017. The audit contained little information as to what was checked, with the majority of areas incomplete or left blank. Where areas of good practice were found from the audit, these were appropriately noted. Where areas for improvement were required, these were also documented. The tool had two columns for an action plan. The actions

required to improve the service were not always adequately worded, timeframes for completion were too broad or unrealistic and a staff member responsible for the actions was not listed.

Audits of people's care files such as risk assessments, care plans and reviews of the care documentation were not robust. Checks of the content of staff personnel files were not completed by the provider, however checks from the previous provider dated December 2016 were sent to us after our inspection. A health and safety audit was regularly completed, but the one due prior to our inspection was not carried out. An infection control audit tool was available and completed. This was a simple 'tick list' with reference to some basic features of infection control and prevention. We looked at the results from 17 September 2017. We noted the audit contained information about call bells and chemicals (CoSHH), lifting equipment operation and portable appliance testing. These are not areas routinely checked in an infection control audit. The audit was not aligned with, and had not considered the key aspects within the Department of Health code of practice for infection. This meant the audit completed by staff missed areas normally inspected within infection control checks.

Simple other checks were conducted by staff. The rationale for some of the checks was unclear and repeated by other audits already in place. For example, a daily kitchen audit called "safe daily method" was used. This covered cleanliness, fridge and freezer temperatures and other areas and was completed two day a day. A "monthly check sheet" was shown to us from June 2017. Again this included the fridge and freezer, in addition to medicines fridge and room temperatures, first aid boxes and people's finances. Where areas required improvement, these were noted but not complied into any form of action plan or checked in the next completed audit.

It was not clear whether any form of a continuing improvement plan or action plan was utilised to capture information and actions from the audits and intelligence information the service received. Although we asked to see a copy of any ongoing action plan for the service, this was not provided.

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

Accidents and incidents were reported and recorded by staff. We reviewed two forms. We saw these were reviewed by the deputy manager or registered manager and appropriate steps taken to ensure people were safe. The number of reported incidents and accidents was low, and this meant it was not possible to identify any themes or trends by looking at these .

The service was required to have a statement of purpose. A statement of purpose documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. The statement of purpose was available in the reception area for members of the public to view if they desired. An easy-read version for people who use the service was not provided. The document was not updated and contained incorrect information. We pointed this out to the registered manager who agreed to liaise with the provider and have the statement of purpose updated.

Staff felt they received good support. Although no staff surveys were completed, staff meetings were held. We looked at the minutes from the last staff meeting and saw the topics were mainly related to people's care and not about the workers. We spoke with two staff members who told us about their experience of working at 16 Homeside Close. They said the managers of the service were good at keeping them informed, but hadn't noticed any changes under the new provider and wanted to meet the provider's senior management team. A visit to the service by the provider's chief executive was planned for October 2017.

Both care workers told us that the deputy and registered manager were "hands on", would "chip in" when necessary and "lead by example." The staff explained that the registered manager was in charge of two services and said they didn't "know how she does it." They also felt the deputy manager was a "strong assistant (to the registered manager)." The two staff told us they liked to work at the service because the "service users are an absolute joy (to care for)" and "every day is different." When we asked the staff if there was one thing they could change, they told us they felt a better complement of staff was necessary. They told us if better staff deployment was available, people who used the service would benefit from more trips out into the community.

There were times when the service was legally required to notify us of certain events which occurred. The size and type of service meant that no or a low number of notifications would be sent. When we spoke with the registered manager, they were able to explain all of circumstances under which they would send notifications to us. Our records showed that the service sent two notifications to us, as required by the regulations.

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 17 HSCA RA Regulations 2014 Good governance The registered person had not established an effective system to ensure compliance with regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not always take mitigating action where audits, monitoring and assessment systems identified risks relating to the health, safety and welfare of service users and others.