Telford & Wrekin Council

Carwood Residential Home

Inspection report

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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?	Good
Is the service well-led?	Requires improvement

Overall summary

We carried out this unannounced inspection on 13 January 2015. When we last inspected the home on 2 January 2014 we found the provider was meeting all the requirements.

Carwood Residential Home provides care and accommodation for up to 13 people who have a learning disability. At the time of our inspection there were 10 permanent people and one person on emergency placement with their own support living in five separate flats across the home. The registered manager was no longer in post and had recently submitted an application to CQC to deregister. A service leader was employed and was responsible for the day to day management of the home closely supported by a group 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.

Summary of findings

Staff had received training to keep people safe and knew their responsibility to protect people from harm or potential abuse. They knew how to recognise abuse and how to report it. Improvements had been made to ensure people received their medicines as prescribed. We found staffing levels and the deployment of staff needed to be reviewed to ensure the safety of the people using the service at all times.

People were positive about the care and support they received. We found people were supported by an established staff team who were trained and supported to do their job. We observed positive engagement between staff and people living at Carwood. Staff were kind, respectful and attentive to people's needs. They worked alongside people, helping them with tasks, rather than doing things for them. People's privacy and dignity was respected and their independence was promoted. People took part in some social and recreational activities in the local community however, opportunities were limited during evenings and weekends due to insufficient staffing. People were supported to access a range of healthcare services and their individual communication needs were understood and met.

We found a person's ability to make decisions had not been assessed. Staff training records showed that less than half the staff team had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Not all the staff we spoke with had a clear understanding of possible factors that could contribute to a deprivation of liberty. Improvements were needed to ensure that people's rights were protected.

People were aware of the changes in the management and leadership of the home following a recent restructure of the provider's services. People considered the home was well managed and told us the service leader was open and approachable. We saw the provider had elements of a quality assurance framework in place. However, we found this required improving and more formal ways of capturing people's views and decisions assessed and recorded.

We found three breaches in Regulations 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

There were not always enough staff available to ensure people were adequately supervised to keep them safe from harm. Staff received training in protecting people and knew how to recognise and report abuse. People received their medicines as prescribed.

Requires improvement

Is the service effective?
The service was not consistently effective.

Not all the staff demonstrated a clear understanding of possible factors that could contribute to a deprivation of someone's liberty. Staff had received training to meet people's needs and supported people to maintain optimum health.

Requires improvement

Is the service caring?
The service was caring.

Staff were kind and caring. People's care was based on their individual needs and preferences. People were treated with respect and their independence, privacy and dignity was promoted and valued.

Good

Is the service responsive?
The service was responsive.

People were involved in their care and support. Their support plans were personalised and developed and reviewed with them. People were supported to raise concerns.

Good

Is the service well-led?
The service was not consistently well-led.

Systems for monitoring the quality of the service required improvement. Staff understood their roles and responsibilities and were supported by managers who promoted a positive culture of openness and inclusion.

Requires improvement

Carwood Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 13 January 2015 and was unannounced.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was learning disability.

Before our inspection we reviewed the information we held about the home. We looked at statutory notifications we had been sent by the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home. Following our inspection we sought feedback from health and social care professionals and a relative of a person who had used the service for short-term care.

We met with ten people who were living at Carwood and seven staff to include the service leader, group manager, administrator and enablement workers. We looked in detail at the care two people received, carried out observations across each flat and reviewed records relating to two people's care. We also looked at medicine records, staff training, complaints the provider had received and other documentation relating to the management of the home.

We used the Short Observational Framework for Inspection (SOFI) observation. SOFI is a way of observing care to help us understand the experience of people who lived at the home. We used this because some people living at Carwood were not able to tell us in detail what it was like to live there. We also used it to record and analyse how people spent their time and how effective staff interactions were with people.

Requires improvement

Is the service safe?

Our findings

All but one person who was able to told us they felt safe living at the home. One person said, "Sometimes I'm unsteady on my feet so I stay in my wheelchair". The person also told us about a recent incident that had resulted in them sustaining an injury by another person they lived with. Discussions with staff and managers identified the incident had occurred when the two people had been left unsupervised for a short period of time while the member of staff supporting them had popped out with another person to get a take away meal. We saw the incident had been recorded and referred into the local authority's safeguarding adult process. We were advised by the local authority that this did not proceed to an investigation and a review of the person's care was undertaken.

We spoke with staff about the staffing levels and the deployment of staff across the five flats. Although staff considered people were safe they shared concerns about having to leave people unsupervised. This was while they provided assistance to colleagues in other flats with attending to people's personal care needs.

We were told one member of staff was allocated to each flat. In addition a senior member of staff was on duty and provided support where needed. One member of staff told us, "I think there should be two staff in this flat. If we need support with changing people we have to call for a member of staff from another flat and that leaves other people vulnerable because we can't always rely on the senior as they are so busy". They also told us there were not enough staff on duty to regularly get people out in the evening. This was also reflective of discussions held with another member of staff and our observations. Another member of staff told us, "We're short staffed but we cope". Staff told us that people were left between 10 – 20 minutes unsupervised when they had to attend to the personal care needs of people who required two staff. We were told three of the 11 people currently living at the home required the assistance of two staff to attend to their personal care needs. Managers acknowledged the need to increase staffing across the home and told us about the proposals that were currently out to consultation. These included 'adjusting staffing levels to accommodate the provision of personalised day activities for people living at the home and a substantial overhaul of existing rotas to ensure the right number of staff with the right skills were on duty at the right times'.

We found that the registered person had not protected people against the risk of unsafe staffing levels. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the staffing rota reflected the staff on duty at the time of our inspection. We saw there was a good skill mix of staff on duty. This included the service leader, an administrator, a senior enablement worker and enablement workers. Staffing absences were predominantly covered through the use of existing staff. Casual and agency staff were only used if deemed necessary and every effort was made to obtain staff who were familiar with the home and people's needs. This helped provide continuity of care for people living at Carwood.

We saw the home had obtained additional staffing to support a person who was admitted to the home for emergency short-term care. They had ensured the person was compatible with the other person sharing the flat, who was also receiving short-term care. We saw there were arrangements in place that ensured people receiving short-term care did not impact on those living in the home on a permanent basis.

We saw the home and equipment was well maintained. A relative of a person who had recently stayed at the home told us staff had made every effect to make the environment safe for them. People living at Carwood had access to information about abuse. We saw an easy to read guide was held in the main reception area of the home. The guide detailed what abuse was, what the person needed to do about it and what the home would do about it. Staff we spoke with confirmed they had received training in protecting people from harm and demonstrated a clear awareness of the types of abuse. They were aware of what to do if they suspected wrongdoing at work. One member of staff told us, "I wouldn't have a problem speaking up. I've not observed any poor practice but if I did, I'd speak up immediately". Staff were aware of how to make a referral into the local safeguarding adult process.

Requires improvement

Is the service safe?

No new staff had been recruited since the last inspection. Discussions with staff on duty confirmed they had been recruited safely and all the relevant checks had been obtained before they commenced working at the home. We spoke with a people's services officer based at the provider's head office. They described the recruitment procedure to us and were confident these procedures were robust and safeguarded people using the service.

Information we hold about the home demonstrated that the provider had taken prompt action when allegations of abuse were reported to them. Since our last inspection there had been an investigation led by the local authority. The local authority take responsibility for investigating concerns about alleged abuse. The provider had notified us about safeguarding incidents concerning medication errors and the investigation was concluded and allegations of neglect substantiated. We saw the provider had taken action regarding the staff members concerned and reviewed medication procedures to make sure people living at the home were protected from risk of harm or abuse. Staff also spoke about the procedures they had in place to safeguard a person who was particularly vulnerable when they were away from the home on their own.

We saw the provider used risk assessments to help identify and manage the risk of harm to people. We found risk assessments had been completed for the people whose care we looked at in detail. These included medication, mobility, health emergencies and in-house and community activities. The service leader told us about the safeguards they had in place for a person with capacity who was particularly vulnerable when out alone in the community. We saw information was also available for staff on how to best support a person whose behaviours challenged. This meant staff supporting people had the information they needed to care and support people safely. We saw one person enjoyed smoking. To enable them to do this safely, while minimising risk, a smoking shelter had been installed outside and the person was encouraged to wear high visibility and smoke proof clothing.

Staff were aware of the reporting process for any accidents or incidents that occurred. We saw copies of completed reports had been sent to the provider's health and safety department. This ensured all accidents and incidents were monitored to identify patterns or trends to help reduce reoccurrences. We saw a person was wearing protective headgear to minimise the risk of injury to themselves in the event of having a seizure. Bed rails were in place for people assessed as requiring them to maintain their safety.

We spoke with people about their medicines. One person said, "I have my tablets in the morning and at night. They put them in my hand and I swallow them". We looked at how people's medicines were managed. We reviewed the revised procedures that had been put in place following an investigation where people did not receive their medicines as prescribed. We saw people's medicine was securely stored in their own room and in accordance with good practice. People's medicine administration records were completed and up to date. This showed that people were receiving their medicine when they needed them and in the right quantities as prescribed. The service leader told us about the action they had taken in relation to medicines belonging to a person admitted to the home in an emergency. We saw they had followed policies and procedures to safeguard the person concerned and staff responsible for administering medicines. They had also liaised with health professionals and printed off information sheets for staff about the person's prescribed medicines. This ensured staff had all the information they needed to make sure the person got their medicines safely and as prescribed.

As a result of the recent investigation only senior staff administered medicines to people. We saw their competency had been checked and weekly and monthly audits were undertaken. A senior member of staff described and showed us how medicines were ordered, received, administered and disposed of. Staff felt systems had improved due to there being fewer staff involved in the process therefore reducing the chances of human error. One member of staff told us, "We're very hot on meds". We were told one person administered their own medicine under staff supervision and there was a risk assessment in place to support their choice. We saw one person needed to have their medicines administered directly into their stomach through a tube. The provider had ensured that the necessary safeguards were in place to ensure that these medicines were administered safely by staff trained to do so.

Requires improvement

Is the service effective?

Our findings

We looked at the Mental Capacity Act 2005 (MCA) and how this was being implemented. This is a law that provides a system of assessment and decision making to protect people who do not have capacity to give their consent. We also looked at Deprivation of Liberty Safeguards (DoLS). DoLS aims to make sure people receiving care are looked after in a way that does not inappropriately restrict their freedom. The group manager understood the requirements and implications of this law and the effects it can have on people. We were shown copies of the applications that had been submitted by the registered manager to the local authority who were assessing these. We saw an application that had been authorised to deprive a person of their liberty; however we had not been notified as required. The authorisation had recently expired. We were told that a further application had been submitted. Training records showed that less than half of the permanent care staff had received training in the MCA and DoLS including the service leader. The service leader told us that workshops were being developed and they were awaiting dates to attend. Staff we spoke with did not demonstrate a clear understanding of DoLS and what may constitute a deprivation of liberty.

We found that a person's capacity and ability to make decisions had not been assessed. Therefore we could not be confident that any decisions made were made in the person's best interests. The person had moved to a ground floor flat due to the deterioration in their health and mobility. They confirmed they had been involved in this decision. We saw an email detailing that a meeting had been held with the person concerned, their key worker and a health professional to discuss the proposal that was agreed. However, this meeting and decision had not been documented in the person's care records. Managers told us, "We need to get better at evidencing decisions".

We found that the registered person had not protected people against the risk of not obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to told us they liked the staff. One person said, "I like the staff. Staff are kind. They take the time to chat to me". We observed people were relaxed in staff presence. We saw staff had the knowledge and skills to carry out their roles and responsibilities effectively. Discussions with staff showed they were knowledgeable about people's individual needs and preferences. One member of staff said, "We know people's needs really well and can read them like a book".

We saw people were supported by an experienced and established staff team, many of whom had worked at Carwood for a number of years. Staff told us they had received an introduction to their work and had worked alongside experienced staff until they felt confident and competent to carry out their work. We spoke with an agency member of staff who was on duty. They told us it was their first shift at the home and they had been shown around the home and had been given time to sit and read the care plan of the person they were supporting. They also said their training had been checked. They told us about their previous care experience that included supporting people with a learning disability, mental health conditions and dementia. We saw the agency worker had been provided with an information pack about the home. This included detailed information about safeguarding, confidentiality, health and safety and compliments and complaints. Staff told us they attended regular one to one and team meetings. These processes gave them an opportunity to discuss their performance, identify their training needs and make suggestions for improvements to the service.

A relative told us, "The staff coped very well with meeting my [relative's] specific needs. They went above and beyond. I was amazed by them and couldn't thank them enough". Staff told us they received "very good" training opportunities to keep people safe and to meet their individual needs. One member of staff told us they had recently completed a distance learning training course on dementia care. They said the course had developed their skills and knowledge in supporting a person living at the home who had recently been diagnosed with dementia. We looked at the staff training plan. This showed that a number of staff required updates across many areas to ensure their skills and knowledge were maintained. This was fully acknowledged by managers who advised that training over the last 12 months had been minimal due to

Requires improvement

Is the service effective?

budget implications. They told us the provider had recently appointed a development and learning facilitator for its residential services. They said the facilitator would be planning future training events shortly.

We spoke with people about how they enjoyed the food at the home and whether a good choice was made available. One person told us, "I choose my food. I enjoy mealtimes". People said they chose what meals they wanted. We saw differing menus were displayed in each flat. We found that people's individual food like's and preferences were provided. During the day one person was supported to make a casserole for their evening meal. They later told us they did not like casserole. A member of staff said an alternative choice would be offered. We observed people being supported with their evening meal. The atmosphere was relaxed and people were encouraged to eat and drink. Where people required support with eating this was offered sensitively and discreetly. Care plans included information about people's preferences for food and drink. We saw food and fluid charts had been introduced for a person recently admitted to the home so that staff could monitor that the person had sufficient food and fluid intake. We also saw a person had been recently assessed by a speech and language therapist and staff were following the recommendations made in relation to their diet and eating.

We spoke with people about their health care. One person told us, "My doctor is [name of doctor], I go and see him". Another person told us they were supported by staff to attend medical appointments such as the doctor, dentist and optician. Staff spoke about the professional input people received to maintain their health and well-being. Records of professional's visits were recorded in people's care records. Following our inspection we gained feedback from a health professional about how the home supported people with their healthcare needs. They told us, "Carwood has excellent staff. The service users are well taken care of and staff use their initiative to contact me if they have a concern about the client's health or medication. I have an excellent relationship with the staff there and they do follow advice given regarding people's health".

Good

Is the service caring?

Our findings

A relative of a person who had recently used the service told us, "I was very impressed with the staff. They were all very friendly and I couldn't thank them enough for the quality of care they provided". People who were able to told us they liked the staff. One person said, "Staff are kind. They take time to chat with me". Another person said, "I like [name of care worker]". Not everybody was able to tell us about their experience of living in the home. We therefore observed how people were supported in their home to help us understand the experiences of people who could not verbally share their experiences. We regularly heard staff and people laughing together. People were involved in their care and support and were relaxed and happy in the company of staff and the other people they shared their home with. Staff relationships with people were strong, supportive and caring. Staff were compassionate, friendly and professional in their manner. They were respectful towards the people they supported and demonstrated a clear understanding of the people's individual needs.

An agency member of staff on duty told us, "The staff have been very caring and responsive and showed me how best I should support the person I'm working with. They've been very approachable and definitely made me feel welcome. I'd come back to work here". A member of staff told us, "We see each person as an individual and have much compassion for them. We give 110% care. I'd live here".

We saw people were offered choices about their care and support. One person told us, "I have a wash in the morning and at night. I'm going to have a nice shower tonight and I'm going to wash my own hair". People told us they were involved in decisions about their care routines. For example, we saw a person who had recently been admitted to the home decline to get out of their bed. Staff regularly checked on the person and offered support and encouragement. We saw the support provided had been documented on their daily records. We saw people were offered a choice of whether they wished to remain in their room or join others in the communal areas of their home.

People had access to advocacy services. Advocates are independent of the service and support people to communicate their wishes. We were told an advocate was due to attend the home to see one person. An advocate had previously been involved with supporting people through a period of change and had previously supported people with completing satisfaction surveys about the quality of the service they received.

The premises maximised people's privacy and dignity because people had access to communal areas where they were able to sit with each other or be on their own. We saw staff knock on people's rooms before entering. A member of staff closed a person's door to their room to protect the person's privacy as they had chosen to remain in bed. Staff shared examples of how they encouraged and promoted privacy in dignity. For example, closing doors and ensuring people's dignity was maintained when providing personal care. They demonstrated a clear understanding of good practice. Training records showed that three staff had received dignity in care training. A member of staff who had received the training told us the training had helped raise their awareness of good practice and values.

People were clean, well-cared for and appropriately dressed based on their individual style. We observed positive interactions and staff provided care and support sensitively and discreetly. Staff were knowledgeable about people's individual needs. They listened to and talked with people appropriately. They were aware of people's preferred form of communication and these preferences were documented in their care records. We saw people being supported to be as independent as possible and do as much for themselves as they were able to. For example, people who required it had the right equipment to promote their independence in mobilising safely around the home.

Good

Is the service responsive?

Our findings

People told about their activities and interests. One person said, “I like words search. Sometimes I go to get a word search book. I get my personal money and go down to the shop next to the doctors”. They also told us they helped with their personal laundry and household recycling. Another person said, “Sometimes I go to town. I've got a bus pass”. Other people told us they attended day services and enjoyed going there. One person said, “We sometimes have meetings to discuss things like benefits, they're quite interesting”.

Staff had a good understanding and were responsive of people's needs. We saw people were at the centre of their care and received the care and support when they needed it. A member staff supported one person who became quite excitable. They reassured the person and explained why they needed to calm down due to their health condition. We later saw the person very upset and vocal following a fall. We saw staff were responsive to the person's needs and helped them to safety and checked they were not hurt. A relative we spoke with told us the staff had been, “very very responsive” to accommodate their relative’s needs. They said on their arrival to the home, “The staff quickly assessed and immediately changed the original support requirements to suit [name of person] needs and increased staffing levels for personal care”.

People’s care needs had been assessed and they had a care plan in place which were individual to each person. Information was readily available on people's likes, dislikes and personal history. Staff were kept aware of any changes in people's needs on a daily basis. This was supported by a system of daily records which were completed by staff and contained information about each person's day and what they had done. There were also short briefings in place between shifts. This ensured staff coming on duty were kept informed of any changes to people’s care and support needs. Staff told us there was good communication between managers and staff.

People's care and support needs were assessed, recorded and kept under review. A relative told us they were fully involved in the assessment and the planning of their relatives’ care and support. They said, “The manager listened to me and implemented everything we wanted”. They said their relative visited the home on a number of occasions in preparation for their stay. We saw staff had responded to a person’s deterioration in their health. They had worked with the person and key people involved with the person to ensure their health needs were regularly monitored and they received the support they needed. A member of staff told us they had received training to better equip them to meet the person’s needs. We saw one person had been admitted to the home the previous afternoon for emergency short-term care. The service leader had remained on duty and visited the person’s previous placement and had also liaised with the person’s day service to obtain as much information about the person as possible. Funding to provide an additional member of staff to support the person had been agreed. We saw staff had detailed information to ensure they were able to meet the person's needs.

Some people were keen to show us their bedrooms. We saw their bedrooms had been decorated to reflect their personal taste and there were photographs and personal mementos displayed. One person told us they had chosen the colour scheme for their bedroom. They told us, “I like my bedroom I do”.

Staff told us they had recently obtained loyalty cards that gave people discounts on activities and events in the community. They also said they were looking to access the Ironbridge museums in addition to hiring push bikes for people with a disability. We saw current opportunities for people to access the community were limited, particularly of an evening and weekend due to staffing levels and the deployment of staff. Discussions identified that if one person wanted to go out in the community with staff support it would be difficult to accommodate if other people sharing the same flat declined to go out. People who attended the provider’s day services told us they enjoyed attending these services. We were told people could remain at home and would be supported by a member of staff on duty if they chose not to attend their day service.

Managers advised us about proposed changes following the deployment of personal budgets to people with an assessed eligible need. This would provide people with more choice regarding how they wanted to spend their personal budget. Proposals included adjusting staffing levels to accommodate the provision of personalised day activities. One member of staff told us they thought the upcoming changes would be better for people using the service. They felt it would provide people with a greater

Good

Is the service responsive?

choice and a more personalised service. This was reflected in discussions held with managers and the staff we spoke with. We were told of plans to utilise the gardens at Carwood and for Carwood to become more self-sufficient. This included growing their own produce. The service leader told us, "We are looking at lots of things to provide a service that better meets people's individual needs".

We asked people what they would do if they were unhappy with something. One person told us, "I would speak to [staff member's name] if I was unhappy". Another person said, "If I'm unhappy I talk to [names of the people they shared their flat with]. Staff shared examples of what they would look out for if a person was unable to verbally tell them they were unhappy. Examples included a change in a person's mood or body language. We saw people had information about how to make a complaint in an easy to read format. The procedure was available in the main reception in addition to a suggestion box. Staff were familiar with the complaints procedure. We saw the provider had received one complaint since the last inspection.

Requires improvement

Is the service well-led?

Our findings

We looked at how quality was monitored in the home. The provider had elements of a quality assurance framework in place. For example we saw the provider had learned from mistakes relating to medicines management and had improved procedures to safeguard people. Audits were undertaken. These included medicine management, people's finances, staff sickness monitoring, monthly spot checks and health and safety. Accident and incidents were recorded and copies sent to the provider's health and safety department so that any emerging trends or themes were monitored and actioned. Our records showed that the provider had notified us of significant events that had occurred in the home with the exception of a DoLS authorisation concerning one person and changes to their statement of purpose. The complaint we found recorded in the complaints log had not been followed through therefore the person or their representative could not be assured concerns raised had been addressed. Recommendations made by the Environmental Health Officer's inspection in February 2014 concerning paint work in one flat had been actioned but not met. Following this inspection we have been informed that this has since been met.

Staff told us they were provided with opportunities to share suggestions for improvement during one to one and team meetings. One member of staff told us, "We're asked for suggestions on how we do things better". Managers were unaware of when the last satisfaction survey had been undertaken to gain people's views on the quality of the service. We were told this was usually done every 12 months and an advocate had previously supported people to complete the questionnaires. Following the inspection a senior manager for the organisation told us, "During 2014 we looked to undertake a wide range of consultation with all service users, family carers, staff and partner agencies**.** During this time information and feedback was gathered from individuals to establish how people felt about the quality of their current services and how they would like to see services look in the future. The advocacy service supported visits and engagement sessions with all service users. The consultation informed decisions about the remodelling of services**.** The results of the consultation and future service delivery plans were distributed to all stakeholders and copies including an easy read summary".

Feedback was also gained from people using the service during reviews and meetings held with key workers. However, views gained had not been documented on the care records we reviewed. Feedback from relatives and visiting professionals about the quality of the service had not been sought. A formal audit to identify and manage the quality of the care provided had not been completed. We were advised no visits had been undertaken by the provider's own quality monitoring team since 2013 to assess quality. We were told a request for a further audit by the service co-ordinator had been requested in addition to an audit by Healthwatch. The group manager told us they visited the home but their visits were not recorded. Managers told us they were looking to introduce formal audits to include service leaders auditing other services managed by the provider.

We found that the registered person had not protected people against the risk of not having effective systems in place to monitor the quality of the service delivery. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had left their post on 30 November 2014 and had recently submitted an application to us to deregister. A service leader was employed at the home and was responsible for the day to day management of the home. They were closely supported by a group manager, who was new to the service and offered operational management support. The service leader told us, "I am learning and dedicated to my job". We were told an application to register a new manager would be made once a decision had been made on who was to be registered.

People we spoke with were aware of who the managed the home. One person told us, "I like [name of service leader]. She's nice". People were aware of the changes in the management and leadership of the home following a recent restructure of the provider's services. We saw a new management structure was in place. Adult provider services had moved out of adult social care in March 2014 to become part of customer services. One of the main reasons for the move was the decision to deploy personal budgets to people using services to provide them with a greater choice of who to purchase their care from. We were told proposed changes would not impact on people who

Requires improvement

Is the service well-led?

used the service but would impact on staff. Managers shared a detailed account of the changes with us and acknowledged proposals would financially impact on the staff. Although discussions held with staff identified they were anxious they told us they were kept informed of the proposed changes. This was evidenced in the minutes of a recent staff meeting held. Staff spoken with considered people using the service would benefit from the proposed changes through offering greater choice

The group manager told us they visited the home on a weekly basis to provide support to the service leader and maintained regular contact by telephone and email. They said they were always available to offer support at all times. Visits made to the home by the group manager were not documented therefore managers were unable to evidence discussions held and any identified actions required. Managers demonstrated they were aware of their role and responsibilities and they understood the values of the organisation, the strengths and areas for service improvement. They told us, “We know where we need to get to and we’re putting everything in place to get there”.

The atmosphere in the home was welcoming and we observed positive interactions between people using the service and the staff. Discussions held with managers and staff showed there was a culture of honesty and transparency. Staff we spoke with told us they enjoyed working at the home and supporting the people in their care. Staff were positive about how the service was managed despite the proposed changes to their terms and conditions. They felt changes would be in people's best interests. They considered the service was well-led and told us the service leader operated an open door policy and was very approachable. One member of staff told us, “[Name of service leader] is 100% supportive and goes above and beyond the call of duty. She wouldn't ask me to do something that she wouldn't be prepared to do herself. She's a good boss”.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There was not suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to monitor the quality of the service delivery.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People's health, safety and welfare was not always safeguarded because the provider had not taken appropriate steps to ensure that at all times there are sufficient numbers of suitable, qualified, skilled and experienced persons employed to meet people's needs.