Primrose House (Morecambe) Limited

Primrose House

Inspection report

Middleton Road
Middleton
Morecambe
Lancashire
LA3 3JJ
Tel: 01524 853385

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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

Overall summary

This unannounced inspection took place on 14 May 2015 and 21 May 2015.

Primrose House provides accommodation and personal care for up to 6 people with learning and physical disabilities. The home is a purpose built, single floor dwelling. There are disabled facilities and a range of aids and adaptations in place to meet the needs of people using the service. There is also a sensory room on site.

A registered manager was in post at the time of the inspection. A registered manager is registered with the Care Quality Commission to manage the service. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in July 2013. The home was found to be fully compliant at the last inspection.

There were three people living at the home on the day of inspection. Only one person who lived at the home could verbally communicate. This person informed us that they were very happy living at the home and gave positive

Summary of findings

feedback about the staff. We observed the interactions and body language of the other two people who lived at the home to try and understand their experiences of the care provided.

We observed positive interactions between staff and people who lived at the home. We observed staff engaging in meaningful conversations with people. Staff were kind, patient, and compassionate and were caring towards people.

Feedback from relatives in relation to care provision was positive. Family members stated that their relatives were happy living at the home and that they were well cared for.

Records retained by the provider showed us that robust pre-recruitment checks were in place prior to any person being employed by the service. Staffing levels were appropriate to ensure that people were kept safe but staffing levels did not always allow person centred care to be achieved. People were at risk of being socially isolated as there were not always enough staff on duty to enable people to access community facilities.

One person told us they felt safe and secure living at the home. Suitable arrangements were in place to protect people from the risk of abuse. Safeguards were in place for people who may have been unable to make decisions about their care and support.

We looked at how medicines were prepared and administered. We saw medicines were given in a respectful manner and systems were in place to ensure that all medicines were stored securely and effectively. However good practice guidelines were not always followed. Staff did not always follow directions as stated on the Medication Administration Record.

We found people were involved in decisions about their care and were supported to make choices as part of their daily life. Each person had a detailed care plan which covered their support needs and personal wishes. However we found that these plans had not been updated at regular intervals. This meant that staff were at risk of not having up to date information about people's needs and wishes. Records showed there was a personal approach to people's care and they were treated as individuals.

Staff spoken with were committed to providing a high quality service and confirmed that team work between the team was good. However morale in general was low. Staff said that there was sometimes a lack of leadership from the registered manager. The provider was currently considering implementing major changes within the service but staff felt that they were not included in this process of change. Staff said that training did not happen as much as it used to and felt that supervisions were sometimes too infrequent. Staff did not always feel supported to carry out their role effectively.

Relatives we spoke with gave positive feedback about the service and how they were communicated with. No relatives had any complaints about the service. The provider had a complaints system in place but this was not always effective as one person who lived at the home told us that they did not have any complaints but did not know how to complain.

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?

Requires Improvement

The service was not always safe.

General feedback from a person using the service and relatives was that the service was safe. However we found suitable arrangements were not in place to ensure medicines were safely administered. This was because we found errors in the recording of medicines administered to people who lived at the home.

On the day of our visit we saw staffing levels were sufficient to keep people safe. People had their needs met in a timely manner

Staff understood the procedures in place to safeguard vulnerable people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had failed to ensure that their training and development plan was up to date. This meant that staff did not always have access to ongoing training to meet the individual needs of people they supported.

The provider had policies in place that ensured they met the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This meant there were safeguards in place to keep people safe.

We observed people being offered choices as to what they wanted to eat. Records showed that people's nutritional needs were met.

The management and staff at the home worked well with other agencies and services to make sure people's health needs were managed.

Is the service caring?

Good

The service was caring.

The service demonstrated great commitment to providing person centred care. There was evidence that people's preferences, likes and dislikes had been discussed so staff could deliver personalised care.

Staff treated people with patience, warmth and compassion and respected people's rights to privacy, dignity and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

Staffing levels dictated the quality of the service provided to people who lived at the home. Preferences were not always achieved as detailed in the person centred care plan. At times people were socially isolated and were sometimes restricted from carrying out their hobbies and interests.

Records showed people and their family members had been involved in making decisions about what was important to them. People's care needs were kept under review and staff responded quickly when people's needs changed.

The management and staff team worked very closely with people and their families to act on any comments straight away before they became a concern or complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

Relatives were positive about the skills and attributes of the registered manager and staff described the registered manager as approachable.

Morale between staff was low as staff felt that they were not informed of planned changes to the service. We noted that the registered manager was working a variety of shifts to support staffing levels. However staff told us that this sometimes meant that the manger was not always available to undertake management responsibilities.

The registered manager undertook monthly audits of care plans but these were not always effective. Records were not always up to date and people had not had their care plans formally updated for three years.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health & Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Heath & 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 was an unannounced inspection carried out over two days on 14 May 2015 and 21 May 2015. The team consisted of one adult social care inspector. The adult social care inspector returned to the home (unannounced) for a second day to complete the inspection process. Prior to the inspection taking place, information from a variety of sources was gathered and analysed. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and the information was considered when planning the inspection.

Information was gathered from a variety of sources throughout the inspection process. We spoke with four staff members, including the registered manager. We also spoke with a student nurse on placement and a coordinator of the board of Trustee's who was also a relative of a person living at the home.

We also spent time with people who lived at the home to see how satisfied they were with the service being provided. We observed interactions between staff and people to try and understand the experiences of the people who could not verbally communicate. After the inspection we also spoke with two relatives to discuss how satisfied they were with the care provided.

As part of the inspection we also looked at a variety of records at the home. This included the care plan files belonging to the three people who lived at the home and recruitment files belonging to four staff members. We also viewed other documentation which was relevant to the management of the service.

We also looked around the home in both public and private areas to assess the environment to ensure that it was met the needs of the people who lived there.

Requires Improvement

Is the service safe?

Our findings

We spoke with one person who lived at the home. The person told us that they enjoyed living at the home and felt safe there.

We also spoke to two relatives who both said that they were happy with the service provided. One relative said, "My [relative] is completely safe here. My [relative] would not be here if they were not safe."

People were protected from abuse and avoidable harm as all staff were aware of what constituted abuse and how to report it. Staff said that they would not be hesitant in reporting abuse should they see it occurring. One staff member said, "If I thought someone was being abused, I would go to my manager. If they did nothing about it I would go to CQC (Care Quality Commission)."

Staff were also aware of whistleblowing and the right to report it. One person said, "I wouldn't hesitate, I would report things straightaway if I thought things weren't right. I've a lot of experience in care and would not be afraid to raise concerns if I thought that people were not receiving good care."

The provider had a comprehensive safeguarding policy in place which detailed contact numbers of the local authority and other relevant contact details should a member of staff need to make a safeguarding alert. We also observed an easy read version of the safeguarding policy with pictures, which aimed to promote knowledge and awareness of the rights of people who lived at the home.

The registered manager spoke with us about a recent safeguarding alert that had been raised. The registered manager demonstrated that they had developed robust procedures to deal with safeguarding concerns. The board of trustees (who were also the provider) were proactive in dealing with safeguarding alerts and also carrying out their own internal investigations as required. This showed us that the provider was transparent and had developed a culture of learning from incidents.

We looked at accidents and incidents that had occurred at the home. We noted that staff kept up to date comprehensive records of accident and incidents. These were given to the registered manager, who analysed each accident and incident and took appropriate actions to minimise the risk of these happening again.

The provider ensured that people were kept safe by maintaining equipment appropriately. We noted that hoists had been serviced and annual checks were in place for the gas and electric services at the home. We also noted fire extinguishers had been checked as part of a fire audit and a comprehensive system was in place for dealing with fire.

The home was maintained to a high standard. We saw that the cleanliness of the home was good. The registered manager had a cleaning schedule in place and records showed that this was consistently applied. There were no unpleasant odours in any areas when we inspected the home. There were adequate hand washing facilities available in all bathrooms and we observed staff wearing personal protective equipment (PPE) when appropriate, to prevent any cross infection.

We looked at four weeks rotas to assess staffing levels. On the first day of inspection there were three staff on duty and one student on shift in the morning. This reduced to two staff in the early afternoon. Observations showed us that staffing levels were appropriate to keeping people safe. Staff were not rushed and had time to carry out their duties as well as spending time with people who lived at the home. However we did note that should people wish to spend time in the community staffing levels did not always support this.

Care records demonstrated that one person who lived at the home required two carers to support them when out in the community. On the day of inspection this person went out for the day with only one member of staff. The registered manager said that they had risk assessed this but there was no documentary evidence to show that this had happened. The manager said that controls were in place to minimise any risk of harm. We could not assess the effectiveness of the systems in place at this time due to the lack of paperwork.

The registered manager had completed a piece of work alongside the Local Authority to look at staffing levels during the night. As a consequence of this piece of work there was only one member of staff on duty at night time. The registered manager said that they had risk assessed the situation and that a Trustee who lived across the road was on call in an emergency. Systems had been put in place to ensure people's needs could be met by one person of staff.

Requires Improvement

Is the service safe?

We asked the registered manager for copies of personal evacuation plans for each person to ensure that there were safe systems in place should the provider need to evacuate the building. The registered manager said that personal evacuation plans were in place but did not submit these to us as requested. We were given however a comprehensive plan as to how the provider would deal with a fire. This showed that the registered manager had assessed the risk and systems were in place to manage staffing levels in an emergency.

We looked at how medicines were stored, and administered. Medicines were ordered appropriately, checked on receipt into the home and stored correctly. We observed one staff member administering medicines. The staff member gave each tablet separately and told the person before they administered it, what each tablet was. This showed that the staff member asked people to consent before they took the medicine.

Medicines were dispensed by the pharmacy into individual sealed dispensers The provider told us that they were in the process of changing the administration system as the written information held on the dispensers was easily wiped off. This posed a risk as medicines may become unidentifiable and may be given to the wrong person. The showed us that the provider was proactive in considering risks to medicines and looking at ways to eliminate risk.

Although the home had a good system in place for the management of medicines we found that protocol for irregular medicines (PRN) medicines were sometimes unclear. Directions for PRN medicines said “Use as directed,” The provider did not have any further documentation to state when this should be given and what for. This could lead to confusion as to when and when not to prescribe medicines.

Record keeping for medicines were sometimes incomplete or indicated that medicines had not been administered as directed. We noted that one person’s records said that they should be prescribed their medicine twice weekly. On one occasion, it was only signed to indicate it had been administered once in one week and then was signed for as administered three times the week later. On the same MAR sheet we noted that another drug was detailed as being administered each morning but the records indicated that it had only been administered once that week.

We found that one person was being administered a multi vitamin tablet daily. This multi vitamin was hand written on a MAR sheet. This person was also prescribed medicines by their doctor. We asked the provider about homely remedies and whether or not they had a system for this. The registered manager advised that they did not have a homely remedies policy in place.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010, Safe Care and Treatment as the Registered Manager did not have systems in place to ensure medicines were managed appropriately.

We looked at recruitment files belonging to four staff. We found that people were safe because they were protected by safe recruitment of staffing at the home. The registered manager ensured that two references were sought for all employees before people commenced work. This included a reference from their previous employer. Although we could not find copies of any personal identification of staff on file, we found a pre-employment checklist which had a pre-requirement of viewing a person’s identification upon it. The registered manager advised is they they did check identification prior to people commencing work but shredded this information due to data protection legislation afterwards. The registered manager agreed that they will keep a record of all documentation viewed in future before shredding. We also observed copies of interview records in files that demonstrated that the registered manager checked people’s skills and abilities to perform the role prior to offering people employment.

Staff were not permitted to work at the home until a valid Disclosure and Barring Service (DBS) check was in place. A DBS certificate allows an employer to check the criminal records of employees and potential employees to assess their suitability for working with vulnerable adults. This prevents people who are not suitable to work with vulnerable adults from working with such client groups. These checks demonstrated that effective systems were in place to make sure that staff were only recruited who were safe and suitable to work with vulnerable adults.

Staff had a good understanding of each person who lived at the home and knew each person’s needs well. This meant that staff knew how to keep people safe and manage individual risk. We looked at all three residents care plans and risk assessments to see if risks were identified and appropriately managed to ensure that risk of harm was minimised. All three care plans had comprehensive risk

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Is the service safe?

assessments in place. We noted that some risk assessments were very person centred and took the views of the person into account. In one situation the registered manager had been creative developing ways to balance risk against personal choice. One person was at risk of falling from their bed, but the home had assessed this risk and put controls in place that were less restrictive than bed rails. A staff member said, "We know [person using the service] wouldn't like bedrails, we don't want to stop them from being able to get up out of bed at night, so we have balanced the risk (of them falling) and have a system in place which allows them to be able to wander during the night. They often get up from their bed during the night."

Although we saw that risk assessments were in place and were reviewed we noted that one person's health needs were documented as having changed over the year but these changes had not been updated onto the care plan and risk assessment. This meant that the documentation did not reflect what care should and was being given.

Requires Improvement

Is the service effective?

Our findings

People and relatives we spoke with said that they were happy with the care being provided. One person said, "Its good here, I get a good cup of tea off the staff."

One relative we spoke with said, "Staff are great, they just get on with it. I have no qualms about any of them."

We asked staff about training provided to enable them to carry out their role effectively. Staff said that although they received training this was infrequent. One member of staff said, "We do receive training, I've had moving and handling training and medication management training this year but I haven't done much else for a long time."

We asked the registered manager how they monitored staff training to ensure that people were appropriately trained. The registered manager did not have a central recording system to show training for the full staff team. This made it difficult to assess the training requirements of the staff team as a whole.

Training records were kept for each individual within their personnel file. We looked at five staff files and found that although a training record was in place for all staff, these had not been updated since 2013. The registered manager said that staff had definitely had training in the past year but they had not had time to update the records. The registered manager said that they would provide further evidence to show that staff had received training . However the registered manager did not have copies of certificates for staff and had not updated training grids and could only provide email evidence of some course bookings.

The provider had a three year training and development plan in place for all staff; however this had not been adhered to for the past two years. This meant that workforce planning had not occurred and some staff training was out of date. This demonstrated that the registered manager did not have appropriate systems in place to ensure that staff were trained.

We received conflicting information about the frequency of staff supervisions. All staff said that supervisions took place but not as often as they would sometimes like. Supervisions enable staff to spend time with their line manager to discuss their practice, in particular any problems they may be facing and identifying training needs. One person told us that they had not had supervision for over a year. However when we looked at supervision records kept by the registered manager these showed that supervisions took place quarterly with staff.

We asked staff about appraisals and staff told us they did not have appraisals. This was confirmed by the registered manager who stated that appraisals were out of date for staff. Records showed us that appraisals had not been completed for over two years.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014, Staffing, because the registered manager did not have appropriate systems in place to ensure that staff received effective training, supervisions and appraisals.

We looked at induction records for new starters. Records showed us that all staff received a comprehensive induction at the start of their employment. We spoke with a student on placement who confirmed that they shadowed the registered manager at the outset of the placement to ensure that they were confident and competent to work with the people who lived at the home.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. In situations where the MCA should be, and is not implemented then people are denied rights to which they are legally entitled.

The home had a policy in place in relation to the Mental Capacity Act 2005 and DoLS and staff demonstrated a good understanding of the Act and how it applied in practice. The registered manager informed us that they had applied through the local authority to restrict people of their liberty but had not yet received confirmation that applications had been approved.

Requires Improvement

Is the service effective?

The provider had documents in place to show that they had assessed people's capacity prior to any decisions being made for that person. The documentation also showed that decisions agreed were the least restrictive for that person. Documentation also evidenced that other people had been involved in the making of the "Best interests" decision.

Alongside this documentation the provider had decision making agreements in people's files. These documents showed what decisions the person could make for themselves, what decisions could be made on their behalf by the staff team and decisions that required input from health professionals, relatives and other relevant parties. This showed that people were encouraged to be involved as much as possible in making their own decisions and people were encouraged to be autonomous and independent.

We observed breakfast and lunch being served. Both occasions were relaxed affairs and personal to the people who lived at the home. People were able to choose what time they ate their lunch, what they wanted to eat and where they wanted to eat on each occasion.

We observed positive interactions over the course of lunch. We observed one member of staff, offering choices to the person before they decided what they would like to eat. One person came into the dining area to eat but then changed their mind and did not want to eat. The staff member asked the person if they wanted to eat in their bedroom and took them to their bedroom. On another occasion we observed a staff member touching the person's face to prompt them to turn their face to eat. The staff member said that they knew if the person was full or did not like the food they would no longer turn their face. This showed that staff took time to understand and respect people's wishes and preferences by understanding body language.

Care records showed that the provider actively sought advice and guidance from other professionals in a timely manner. We saw evidence of referrals to speech and language therapists (SALT) occupational therapy, physiotherapy and epilepsy services. The provider kept records of all health appointments and outcomes. This promoted communications between health care providers and staff and contributed to positive health outcomes for people being supported.

Dietary requirements were addressed by the staff team for all people who lived at the home. One person had difficulty in swallowing foods and was prone to choking. The staff followed guidance put in place by the SALT team and pureed the person's food for them. Staff were aware of following protocol to minimise any risk from choking. One member of staff told us, "[The person] likes to go out to the pub for meals. We still go out to the pub even though [the person] needs his foods pureeing. We go to certain pubs, where [person] is known and they puree food for them."

We observed people being offered drinks throughout the day. This meant people's hydration needs were met.

The people who lived at the home also had a health action plan. (HAP) HAP's are recommended for all people with learning disabilities to redress health inequalities faced by people with a learning disability. This showed that the manager was proactive in promoting good health for the people who lived at the home.

Good

Is the service caring?

Our findings

Relatives of people who used the service spoke highly of the staff and described them as "very caring", "amazing" and "excellent." One person said, "I'm very happy with the care the staff provide. They are very good, they are excellent. We are pleased with everything."

All the staff we spoke with were respectful of people's needs and described a sensitive and caring approach to their role. One staff member described the home and the people who lived there as part of their extended family. One staff member said, "As long as they [the people using the service] are alright, that's all that matters."

Throughout the day we observed staff knocking on doors before entering and constantly seeking consent from the people who lived at the home before completing tasks. Care plans were person centred and ensured that people's diversity was recognised and supported. We observed a staff member asking a person who lived at the home their permission to share their personal file with the inspector before sharing it. This showed us that people promoted and respected people's choice and right to privacy.

Care plans and risk assessments covered multiple topics including locking doors when providing personal care and processes for supporting people to get dressed as a means to protect dignity. Observations throughout the inspection process demonstrated that dignity and respect for all people who lived at the home was at the centre of all care practice. Care records focussed upon ensuring that people's dignity and respect was upheld at all times. We observed one person being asked if they would like to go to their room after lunch so that they could tidy themselves up. The staff member took the person to their room and assisted with the task where needed. This demonstrated that the staff member cared for the person they were supporting and was committed to promoting the persons independence.

Staff spoke fondly and knowledgeably about the people they cared for. Staff showed a genuine interest for people who lived at the home and developed interactions with each person. One staff member started a conversation with one of the people by asking them about their football team and the result from the last game. They were laughing and joking with the individual, making light hearted conversation. The person responded and laughed with the staff member.

We found some staff that went "the extra mile." One member of staff came in voluntarily to enable one person carry out their hobby. They both supported the same football team so went to matches together. The person spoke very highly of this member of staff. They said, "I like [staff member] very much, they make me happy."

Routines at the home were sometimes tailored around the people who lived at the home. We looked at care notes for one person and they demonstrated that this person chose their own bedtime and this was not restricted by staffing. The person was allowed to mobilise around the home and choose when they went to bed. We observed in records that this person had fallen asleep in the lounge. Staff reported that they did not want to disturb the person, so they went to their room and found blankets to keep them warm.

We asked relatives if they thought staff were caring. One relative said, "Nothing is too much trouble for the staff, they will do anything that you ask."

Although two people could not verbally communicate their needs it was evident that the staff on duty knew the people well and could respond appropriately to people's needs. In order to promote interactions staff had developed communication passports for the people who lived at the home. Communication passports draw together information based on how a person behaves and what people think that behaviour means. This documentation then increases interaction and understanding between people who lived at the home and staff.

We also found that staff used objects of reference to aid and assist communication with people who lived at the home. Objects of reference promote communication and choice as they are used as visual cues to show that an activity is about to commence. This allows the person to then communicate choices as to whether or not they want to participate in that activity. People who lived at the home felt comfortable around the staff members. We observed one staff member offering one person choices about what they could have to eat. The person confidently asked the member of staff to go slower. The member of staff apologised and then said, "I'm sorry. I've probably

Good

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confused you offering you so many choices." The staff member then proceeded to offer choices again but at a much slower pace. This demonstrated that people were respected and valued by staff.

Staff had also worked in conjunction with an assistive technology company to enable one person who lived at the home to have some equipment designed to aid their independence. The person had his own board that allowed them to be in control of their own TV.

Requires Improvement

Is the service responsive?

Our findings

People were supported to express their views and wishes about all aspects of life in the home. We observed staff enquiring about people's comfort and welfare throughout the visit. One person liked to have their own space. Staff would pop in regularly just to ensure that they were ok and to ask if they required any assistance.

Where people had difficulties communicating, we found staff made efforts to interpret people's behaviour and body language to involve them as much as possible in decisions about their day to day care. Staff also used person centred communication passports as a means to observe and interpret behaviours in order to understand people's experiences.

Staff also responded promptly when people required any assistance. We observed one person who could not verbally communicate, mobilising towards the door to the garden. The staff member on duty instantly knew that this person was telling them that they wanted to go outside. The staff member attended to their needs immediately and went and found a coat for the person to wear so that the person could go outside. The staff member then said, "[Person] loves to spend time outside. They love sitting in the garden."

Care records demonstrated that people who lived at the home and their relatives were involved in the care planning process. Relatives said that they were kept up to date by the provider and were consulted when appropriate. Each person had a comprehensive person centred plan which included a personal history, preferences and interests. There was also a decision making agreement which clearly identified who was able to make decisions when a person needed support with decision making.

There was evidence that people who lived at the home were encouraged as much as reasonably practicable to make their own decisions regarding care. One person's record stated that the person must be encouraged to be as independent as possible and stated that staff should "respect any decisions the person makes". This showed us that the provider considered independence for people who lived at the home and valued their quality of life.

Relatives we spoke with all said that they were welcomed at the home and that positive links were maintained between the families and the staff team. One person went to stay over regularly at their parents.

We noted that all three care plans had been reviewed but not updated since 2012. One person's records said that the person liked to go to college. We asked this person about this and they stated that they no longer went. A staff member said that the college course was stopped by the college. This information had not been reviewed and updated within the care plan.

Another person's file had a physical intervention policy in place dated 2012. We looked through the person's records to see how often physical intervention had been used but found no evidence it was being used. We spoke with the registered manager about this and they informed us that the person no longer required physical intervention. This meant that there were procedures in place in the file that were no longer appropriate.

We also noted that medical reports relating to one person showed that there had been a change in the persons health needs. These health needs had not been updated in the persons care plan. This meant that the person would be at risk if the staff member followed the persons care plan. We spoke with the registered manager about this and they informed us that although the paperwork was not up to date all staff were aware of the changes as this had been communicated through staff meetings. The registered manager assured us that any new staff would also be made aware of this protocol as they would spend a period of time working with the registered manager before working unsupervised.

We asked staff how they were updated of any changes and how they informed the registered manager of any changes. One staff member told us that the provider had meetings to discuss peoples care plans and changes but said that they had never been to any of these meetings and were unsure as to how often the meetings took place. Another staff member told us that they had a daily communication book where information was updated daily regarding each person.

Due to the size of the home activities were tailored to individual's needs and were not formally structured. The home had a pool table and a sensory room and both were used by two people who lived at the home. On the day of

Is the service responsive?

inspection two people stayed at home and spent time in their room relaxing. One person told us that they were having a quiet day as they were tired as they had been out the night before and never returned home until late. We asked this person about activities that were provided The person said that activities "were ok" at the home.

Although care records were concise and included information about people's likes, hobbies and interests we noted that staffing levels had impacted upon peoples abilities to carry out activities of their choosing. This meant that people's preferences as to how they spent their day was sometimes hindered. People were unable to go swimming weekly and carried out activities as their plan stated.

Staff told us that the reduction in staffing levels had impacted upon people being able to access the community. The location of the home meant that public transport was not accessible for people who lived at the home so people had to rely on car drivers to take them out. The registered manager said that there was only two staff that could drive, this impacted upon people. Although we were informed that people had one to one time during the week to go out and access the community. We found that this was not happening as frequently as stated by the individual care plans.

Care records demonstrated that staffing levels were impinging on people's abilities to carry out activities they liked doing. Monthly care plan audits for all three people who lived at the home documented that each person had been unable to go swimming and participate in chosen activities. One care plan audit that took place in April stated, "Due to staffing levels [person] is struggling to attend activities." Another person's care plan stated that a person liked to keep busy. An activities schedule in place from 2011, showed that the person liked having massages and going bowling. Records showed us that this person had not had a massage in seven months. Another person's audit stated, "Continues to not go swimming due to staffing levels". Records showed us that these restrictions had been in place for over three months.

We spoke with a staff member about these concerns and they said that it was a long term issue due to funding difficulties. The staff member said that people did go out on activities but they weren't as frequent as they used to be. This demonstrated that at times, people were socially isolated due to restrictions on staffing. We spoke to the registered manager about this and they said that staffing levels had impacted on people's ability to participate in external activities. The registered manager said that it had been made more difficult by the lack of car drivers employed the location of the home and the lack of access to public transport.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because the provider had failed to ensure that sufficient numbers of staff were deployed to meet the needs of the people using the service.

Staff said that they tried to include the people who lived at the home in everyday tasks. We observed staff asking one person if they would like to peg out the washing and asked another person if they would like to assist in cooking their lunch. One person who lived at the home was also invited by the provider and attended the debrief session we provided at the end of the inspection.

We spoke with the registered manager to see how they dealt with complaints. The registered manager said that they had never had any formal complaints raised about the service and felt that complaints were dealt with effectively and in a timely way before they became complaints. The registered manager said that they had recently dealt with a complaint but it was only raised informally. The registered manager said that the complaint was taken on board by the provider and actions were taken immediately to address issues raised. We saw evidence that action had been taken following the issue being raised. However the registered manager said that they did not keep a formal record of the complaint.

We spoke with one person and they told us that although they had no complaints about the service they did not know who to complain to if they did. We noted that although the registered manager had an easy read complaints procedure in place, this was not readily accessible to people who lived at the home.

Both relatives we spoke with said that they were happy with the service and had no complaints. Both relatives were aware of how to complain. Relatives said that they were regularly consulted with to ensure that they were happy with the service.

We recommend that the provider refers to good practice guidance in how to manage and deal with complaints.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place at the home. The registered manager had been registered with CQC for five months at time of inspection. All the staff we spoke with stated that the manager was approachable and was good at their job. Staff displayed empathy towards the registered manager and the difficulties they faced as a new manager of the home.

Relatives we spoke with were all complimentary about the way in which the service was managed. All relatives said that the registered provider was amenable and accessible and were confident that any concerns they had would be dealt with effectively.

On the day of inspection one staff member had taken unplanned leave. When we arrived there was only the registered manager on shift alongside a student on placement. We were informed that the night staff member had stayed late to assist people getting up. Later that morning one of the board of directors from the charity stepped in to cover the shift. The director was comfortable with providing support. This showed that the provider maintained good links with the home and had a good knowledge of the people who lived at the home.

Although we received positive feedback from relatives, discussions with some staff demonstrated that there was low morale within the home. Information we received from the provider before we carried out the inspection demonstrated that there had been a high staff turnover the year previous. Staff confirmed that a lot of staff had left with just a core of long term staff still remaining. One staff member said, "Most staff left with all the changes." Two staff members said that changes continued being considered by the provider but felt that they were not kept up to date and informed. The staff members said that this caused anxiety and negativity as people were worried about job security. The registered manager acknowledged that the service had undergone some recent difficult challenges that had affected staff morale. We noted however, that there was a poster on the wall of the office from the Directors with communications about potential changes thanking staff for their patience and continued commitment.

Although there was a sense of low morale between the team, staff said that teamwork between the staff was positive. Staff felt supported by other team members. One staff member said, "I love my job, I like working with my colleagues, it's a good job that we have a strong team left. [Registered manager] has a good team here."

Another staff member said that although care was good, the staff team lacked vision and leadership. Another staff member confirmed that there was sometimes a lack of presence from the registered manager. Rota's from the week previous the registered manager had covered four night shifts. One staff member said that when the registered manager covered nights "they hardly saw them." We spoke with the registered manager about this and they said that whilst new systems were being introduced to the night shift system, they felt it important that they also carried out night duties whilst they assessed the job role and the competencies of staff to carry out this role.

We received conflicting information about team meetings. One staff member informed us that they attended team meetings but another two staff had no recollection of any team meetings occurring recently. One staff member said, "We've not had a team meeting for about two years." Team meetings are important to allow communication between staff to take place as well as identifying ways to problem solve. Team meetings also promote consistency within care provision. We looked at the last two records from team meetings. Team meeting minutes were short and one meeting did not include all staff team members. There was no evidence that absent staff members had read the minutes or been offered opportunity to contribute to meetings.

We asked the registered manager about resources available to her to carry out her role effectively. The registered manager informed us that officially her hours should be split equally between care and management but because of "current staffing issues" she was currently providing hands on care with no management time. This meant that she did not have supernumerary hours to cover their paperwork and administrative duties. This reflected in the accuracies of the paperwork at the home.

We spoke with the registered manager and identified some of our concerns regarding the accuracy of information stored in people's personal files and highlighted that risk assessments were not as up to date as required. The registered manager acknowledged that care plans and risk assessments were not up to date. The registered manager said that it was their job to review and audit the care plans

Requires Improvement

Is the service well-led?

but they said that this did not occur as often as they would like to due to the reduction in staffing. The registered manager said that because staffing levels were so low they had not had time to update the documents but assured us that people were not at risk as all staff were given comprehensive training prior to working alone to ensure that they knew the individuals well.

This was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered manager had failed to maintain an accurate, up to date and complete record for each person using the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not always administered accurately in accordance with prescriber instructions. Recording of medicines was not always in line with current legislation and guidance. 12 (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager had failed to ensure that Care records relating to the care and treatment of each person were up to date and fit for purpose. 17 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of suitably qualified staff were deployed to make sure that peoples care needs could be met. 18 (1) The registered manager had failed to ensure that training of staff was up to date. Staff did not receive regular appraisal of their performance in their role. 18 (2) (a)

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.