Royal Mencap Society

Royal Mencap Society - 4 The Stables

Inspection report

Royal Mencap Society - 4 The Stables
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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

This announced inspection of Royal Mencap Society - 4 The Stables took place on 7 & 8 May 2015.

Royal Mencap Society - 4 The Stables is a care home offering a service to four people who have a learning disability. The home is owned by Royal Mencap Society. The home is situated in a residential part of Crosby with close links to public transport links and local community facilities.

Summary of findings

The home is a bungalow and has a large lounge with dining space, bathroom, kitchen and a garden to the rear. There is car parking space on the front drive and on the main road.

The service did not have a registered manager in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run' The organisation had appointed an experienced internal manager as the new acting manager for the service. The acting manager was aware they needed to apply to the Care Quality Commission (CQC) for the position of registered manager.

People appeared comfortable and relaxed with the staff. A relative told us their family member was safe living at the home.

The staff we spoke with told us they had received safeguarding adults training and were aware of what constituted abuse and how to report an alleged incident.

Our observations showed people were supported by sufficient numbers of staff.

People took part in different social activities, some of which were organised social events in the community. Relatives however raised concerns about the current staffing levels and the impact this had on arranging social activities.

We saw the necessary recruitment checks had been undertaken to ensure staff employed were suitable to work with vulnerable people.

Medicines were administered safely to people. Staff received medicine training and had their medicine practice checked to help ensure they had the skills and knowledge to safely administer medicines.

We found a lack of maintenance of the premises and management of risks associated with health and safety.

Care files showed staff had completed risk assessments to assess and monitor people's health and safety.

People at the home were supported by the staff and external health and social care professionals to maintain their health and wellbeing.

The acting manager informed us people who lived at the service needed support to make decisions regarding their care. We found staff were not always following the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. There was lack of consent around aspects of care and treatment.

People's nutritional needs were monitored by the staff. People were offered a good choice of meals in accordance with individual need and choice.

Staff told us they were supported through induction and on-going training. We saw formal supervision and appraisals with staff had not taken place recently.

Staff had a good knowledge of people's care needs and support was provided in accordance with their support plan.

We observed a good rapport between the staff and people who lived at the home. Staff were polite, patient, attentive and caring in their approach; they took time to listen and to respond in a way that the person they engaged with understood.

The home had an acting manager in post. We received positive feedback about the acting manager from relatives and staff. Staff told us the acting manager was approachable and always at the end of the phone.

Staff were aware of the whistle blowing policy and they told us they would use it if required. Staff said there was an 'open' culture in the home and they were able to speak with the acting manager if they had a concern.

Feedback from people who lived at the home and relatives appeared to be limited. Relatives told us they would like to attend relative meetings and be more involved with the service.

On inspection we found there were breaches of regulations in respect of some standards. Although there were systems and processes to assess the quality of the service provided we found that these were not effective.

You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement

Some aspects of this service were not safe.

The staff we spoke with told us they had received safeguarding adults training. They knew the action to take if they were concerned about the safety or welfare of an individual.

Our observations showed people were supported by sufficient numbers of staff. Relatives however raised concerns about the current staffing levels and the impact this had on arranging social activities.

We saw the necessary recruitment checks had been undertaken to ensure staff employed were suitable to work with vulnerable people.

We found medicines were administered safely to people. Staff received medicines training and their medicine practice was checked to ensure they had the skills and knowledge to safely administer medicines.

We found a lack of maintenance and management of risks associated with health and safety.

Is the service effective?

Requires improvement

Some aspects of this service were not effective.

People at the home were supported by the staff and external health and social care professionals to maintain their health and wellbeing.

Staff were not always following the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. There was lack of consent around aspects of care and treatment.

People's nutritional needs were monitored by the staff. People were offered a good choice of meals in accordance with their individual needs and choice.

Staff told us they were supported through induction and on-going training. We saw formal supervision and appraisals with staff had not taken place recently.

Is the service caring?

Good

The service was caring.

People who lived at the home appeared content and relaxed in the presence of the staff.

People at the home communicated their needs and wishes in different ways and our observations showed staff understood and responded accordingly.

We observed a good rapport between the staff and people they supported.

Summary of findings

Staff were polite, patient, attentive and caring in their approach; they took time to listen and to respond in a way that the person they engaged with understood.

Relatives reported they were pleased with the standard of care.

Is the service responsive?

Good 

The service was responsive.

Staff had a good knowledge of people's care needs and support was provided in accordance with their support plan. Support plans were personalised and reflected people's needs and choices.

Relatives were not always involved with care reviews and have requested to be more involved with their family member's care.

People were able to take part in a range of activities, some of which were organised social events in the community

A process was in place for managing complaints. Relatives were aware of how to make a complaint.

Is the service well-led?

Requires improvement 

The service was not always well led.

The home had an acting manager in post. We received positive feedback about the acting manager from relatives and staff. Staff told us the acting manager was approachable and always at the end of the phone.

Staff were aware of the whistle blowing policy and they told us they would use it if required. Staff told us there was an 'open' culture in the home and they were able to speak with the acting manager if they had a concern

Feedback from relatives and people who lived at the home was limited. Relatives told us they would like to be more involved with the service.

On inspection we found there were breaches of regulations in respect of some standards. Although there were systems and processes to assess the quality of the service provided we found that these were not effective.

Royal Mencap Society - 4 The Stables

Detailed findings

Background to this inspection

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

This announced inspection of Royal Mencap – 4 The Stables took place on 7 & 8 May 2015. The provider was given 48 hours' notice because people who lived at the home and staff are out at different times of the day; we needed to be sure that someone would be in.

The inspection team consisted of an adult social care 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 care services.

Before our inspection we reviewed the information we held about the home. This usually includes a review of the Provider Information Return (PIR) but CQC (Care Quality Commission) had not requested one at this time. The PIR 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.

We looked at the notifications the Care Quality Commission had received about the service. We also contacted the commissioners of the service to obtain their views.

During the inspection we spent time with four people who lived at the home. We spoke with the acting manager, three care staff and sought the views of a visiting health professional. Following the inspection we spoke with four relatives.

We looked at the care records for three people, recruitment information, medicine charts and other records relevant to the quality monitoring of the service. We undertook general observations and looked round the home. This included some people's bedrooms (with their permission), the bathroom, lounge and external grounds.

Requires improvement

Is the service safe?

Our findings

We looked at how the premises and equipment was managed to keep people safe. Systems were in place for checking fire alarms, emergency lighting and the hot water supply to the baths and showers. Records seen were current. In respect of testing the hot water tank, the health and safety folder recorded 'not done as the tank is in the loft'. The acting manager told us there was no risk assessment to identify potential risks associated with Legionella. Following the inspection the acting manager completed a Legionella Risk Assessment and a copy of this document was sent to us.

Staff told us they took part in regular planned and unplanned fire drills but they were unable to confirm the most recent dates for these drills. We saw staff had received fire awareness training. We observed the side entrance to the home which was identified as one of the fire exits was blocked by a car. This was rectified during our inspection. Other fire exits were clear.

We found the rear garden in a neglected state. The grass was overgrown and the garden had unwanted items and bags of garden waste. The summer house was being used for general storage, a window was broken and the decking damaged. Two fence panels were 'down' which meant the garden was not secure. The acting manager informed us a group of volunteers were due to clear the garden but no dates were set for this work. The grounds were not safe or suitable for people who lived at the home. We raised this with an area manager during the inspection and the acting manager later informed us that the garden would be cleared and the fence panels repaired by 22 May 2015. The acting manager agreed to inform us when this work was completed.

Completed maintenance records for the premises were not available as these had been archived. The acting manager undertook 'small' jobs, as seen during our inspection, and external contractors used when required. The garage was used as a laundry facility. The garage doors were in need of repair as the wood was badly splintered. Several kitchen cupboards had doors missing though staff told us new kitchen doors were on order.

We asked the acting manager to show us relevant health and safety checks and risk assessments for the building. The acting manager was unable to locate a health and safety risk assessment for the premises. With regard to safety checks, service level agreements were in place for the gas and electrical supply and hoists.

At the time of our inspection we were informed of the most fire safety checks by an external fire engineer. The service report was not available however this was sent to us following the inspection and this was in date. The fire risk assessment for the home made available to us was dated 2008. The acting manager was unable to confirm if this had been subject to review. We asked to look at the personal emergency evacuation plans (PEEPS) for people who lived at the home. The acting manager was not able to locate a PEEP for one of the people who lived at the home. This was completed by the acting manager and made available to us on the second day of the inspection. The remaining PEEPS were dated 2011 and the acting manager was unable to confirm if the PEEPS had been reviewed to record any changes.

A lack of maintenance and management of risks associated with health and safety was a breach of Regulation 15 (1)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we used a number of different methods to help us understand the experiences and views of people who lived at Royal Mencap Society – 4 The Stables. This was because the people who used the service communicated in different ways and we were not always able to directly ask people how they felt about the service. We spent time with four people who lived at the home and we looked at records, met with staff and conducted general observations. It was clear that there was a relaxed friendly atmosphere and people appeared comfortable and at ease with the staff.

People were not able to tell us if they felt safe but we saw staff supporting people in a kind and gentle manner. Staff offered plenty of support when providing personal care and assistance with meals. When a staff member took a person out shopping, the staff took plenty of time to help ensure their comfort and safety when transferring to the car. A relative told us they felt their family member was safe living at the home.

The staff we spoke with told us they had received safeguarding adults training. They knew the action to take if they were concerned about the safety or welfare of an

Is the service safe?

individual. This was mainly around reporting to senior management though they were aware that incidents should also be reported to social services. An adult safeguarding policy was in place and the local area safeguarding procedure was available for staff to refer to. Contact details for reporting an incident to the Local Authority were not readily available. This was brought to the acting manager's attention. A staff member told us they would not hesitate in speaking up if they felt a person was at risk.

We looked at how the home was staffed. Our observations indicated people were supported safely by sufficient numbers of staff. This support was given when people requested it and needed it.

The acting manager provided staffing rotas that demonstrated how they provided sufficient numbers of staff to keep people safe. During our inspection the acting manager was working alongside three care staff (support workers). At night the home was staffed by a care worker and one member of the care team who 'slept in' but was available should their assistance be required. The staffing levels at night had been increased as a person who was living at the home had been assessed as needing a greater level of support at this time. Several relatives raised concerns about the number of staff available during the day, saying this was often only two care staff. One relative was uncertain as to what the staffing levels should be. We fed this back to the acting manager who told that there was now a permanent arrangement to have three care staff on till approximately 10pm at night. They informed us there had been a recent change in staff however relief staff were now recruited for this home and this would help the consistency of the staff team. The acting manager advised us this was being fed back to relatives.

Staff had completed risk assessments to assess and monitor risks people's health and safety. These included activities in and outside of the home which posed a risk to a person's safety. For instance, access to the community, supporting people with their behaviours that may be a concern. This helped to keep people safe and support their independence

We spoke with the acting manager about staff recruitment. We asked the manager for copies of applications forms, references, identification of prospective employees and DBS checks for four new staff. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. The acting manager informed us the recruitment checks were carried out by various departments within the organisation and electronic records held. The acting manager found it difficult to locate the electronic documents to evidence the recruitment checks. They agreed that the current system meant it was not easy to access the information we required. We therefore asked the acting manager to send us the recruitment details following the inspection. On receipt of this information we saw appropriate recruitment checks had been undertaken for staff to work with vulnerable people.

We looked at how medicines were managed in the home. People had a medicine cupboard in their own room for the safe storage of their medicines. The majority of medicines were administered from bottles. We checked a sample of medicines in stock against the medication administration records and found these to be correct. We observed staff administering medicines to people and they signed the MAR (medicine administration record) once the medicines had been taken. This helped reduce the risk of errors and our findings indicated that people had been administered their medicines as prescribed. Topical medicines (creams) were kept in people's bedrooms and signed when administered. People's medicines were subject to regular review by their GP. Handwritten entries on the MARs were not always signed by two members of staff to ensure accuracy of the information recorded.

Staff competencies around the safe management of medicines were checked to make sure they had the knowledge and skills to administer medicines safely to people. Staff told us they underwent a training programme prior to being allowed to administer medicines. Electronic staff training records showed dates when this training had taken place and medicine competency checks had been undertaken by the staff. Medication checks were undertaken each day.

People had a plan of care and a medicine pen picture which provided information about people's medicines and the level of support they required. PRN (as required) medicine guidance was available and staff had a good knowledge and understanding of when people were in pain and required a painkiller.

Requires improvement

Is the service safe?

For people who required their medicines via an alternative route, for example a PEG (percutaneous endoscopic gastrostomy) tube, detailed guidance and instructions were available for the staff. A PEG tube provides a means of feeding someone when their oral intake is not sufficient. Staff who administered medicine via this route had been trained.

The staff carried out domestic duties and we found the home to be clean. There were no cleaning records though the acting manage told us they completed visual checks. We saw the staff had aprons and gloves in accordance with food hygiene and infection control standards.

Requires improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) (MCA). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Policies and procedures were available and provided guidance for staff on how to safeguard the care and welfare of the people living at the home. This included guidance on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (DoLS) is part of the MCA (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The acting manager had attended training in the MCA (2005) and DoLS. They advised us care staff were booked on this training in July 2015.

The acting manager informed us that people needed support to make decisions. There was however no assessment of people's mental capacity to make decisions or a general mental health assessment to assess people's mental health needs. The acting manager told us assessments of this kind had not been completed. The staff were able to give examples as to how people's needs were assessed in terms of any key decisions or issues around people's health and how they involved relatives and health and social care professionals in this. Records showed these were not always recorded as a formal meeting, for example a 'best interest' meeting but more by reporting the outcome from visits by health care professionals and talking with relatives.

Staff were able to describe how people's consent was to care and support was obtained and how this was based upon people's individualised ways of communicating. We saw this during our inspection in respect of staff assisting people with different tasks and activities. We did not see any recorded evidence of people's and/or relative's inclusion and agreeing to the care plan as a whole.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The previous manager had applied to the relevant Local Authority for a DoL authorisation for a person at the home. We asked to see the DoLS plan for this person. The acting manager and staff could not initially locate the paperwork and were unsure whether the application had been authorised. The paperwork was later found and a DoL plan was in place. We were concerned however that this plan was not readily available for staff. The person's supporting plan made brief reference to the DoL's assessment and the use of bedrails for this person. There was no evidence as to how consent was gained as the use of such equipment could be seen as restrictive. The risk assessment for this was being provided by an external health care professional.

We talked with the acting manager about decisions currently being made for other people in the home and whether restrictions to people's liberty might amount to a deprivation of liberty. The acting manager agreed that they needed to assess this with urgency. Following the inspection we were informed by the acting manager that three DoL applications had been submitted to the Local Authority.

Procedures were not in place to obtain valid consent to care and to adhere to the principles of the Mental Capacity Act (2005). This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed and they had a plan of care which included information about their preferences, interests and health and social care needs. This helped to ensure the staff had the information they needed to support people in the way they liked and needed.

Where people had complex health care needs, appropriate specialist health care services were included in planning and providing their care. A health care professional was visiting a person at the home during our inspection. They told us the staff delivered a good standard of care for the person they supported.

Care records showed visits by a wide range of health and social care professionals. These visits were requested when staff had concerns about a person's health or they required support with their healthcare needs. This included visits from GPs, dietician, member of the SALT (swallowing and language therapy) team, district nurse, community mental health team and occupational therapist.

We spoke with staff about their training. Staff told us they had received training in a number of areas such as, moving

Requires improvement

Is the service effective?

and handling, infection control, food hygiene, health and safety, medicines, safeguarding, fire and first aid. They told us they had the skills and knowledge to provide the support people needed.

Two members of staff told us they had attended distance learning around supporting people who live with dementia and also supporting people with a PEG tube. Staff were knowledgeable regarding medical conditions that required specific support and observation as part of the treatment plan.

A new member of staff told us they were currently undertaking their induction and received a good level of support from the acting manager and staff. We were shown the staff induction and this covered areas such as, safety, values and health and safety.

The staff training plan was held electronically and this showed staff completed training relevant their roles and responsibilities. The acting manager informed us this training plan did not hold dates when staff had completed specific training such as dementia care or PEG training. It was therefore difficult to establish when this training was completed though we did see some course certificates in training files to evidence this. The acting manager informed us refresher training in fire safety was required for three members of staff and they were going to arrange this as a priority.

The acting manager told us staff supervisions/performance meetings were held four times a year and this included a staff appraisal. Electronic records recorded staff supervision meetings. The acting manager advised us the last supervision meetings were held in November 2014 and as yet the staff had not received an end of year appraisal. This was due to the fact the previous manager had left around this time. Staff told us they had attended recent performance reviews but were unsure of dates. Following the inspection the acting manager provided us with dates for staff supervision.

Staff told us they received good support from the acting manager with their day-to-day work and that the training they received enabled them to carry out their work safely. The majority of staff had a NVQ (National Vocational Qualification)/Diploma in Care as part of their formal learning in care.

We observed the lunch time meal. The atmosphere was relaxed and everyone was enjoying the social aspects of eating together. Staff supported people in accordance with their individual need and choice. They made sure people had time to enjoy their lunch. For a person who was reluctant to eat and drink, staff offered plenty of encouragement. Staff were patient in their approach and made sure people had sufficient to eat and drink. A relative told us when they visited the home the staff were always seen to be providing regular drinks and different foods for their family member.

All meals were prepared, cooked and served by the staff. People were offered a good choice of hot and cold meals and snacks at different times of the day.

Care plans recorded people's nutritional needs and the support needed with their diet and drinks. People were weighed if there was a concern around weight gain or loss.

Good

Is the service caring?

Our findings

People who lived at the home appeared content and relaxed in the presence of the staff. People at the home communicated their needs and wishes in different ways and our observations showed staff understood and responded accordingly. We observed a good rapport between the staff and people they supported. Staff chatted freely to people about how they were feeling and about day-to-day events and news. Staff took time to listen and to respond in a way that people understood and engaged with.

Staff showed patience and gave encouragement to the people they supported. Staff support was given in a timely manner and there was a staff presence in the lounge to observe people and attend to their needs. For people who needed to rest on their bed, the staff assisted them in accordance with their plan of care and carried out regular safety checks.

Staff were appointed a key worker role and they told us how this role helped them to understand in more detail people's wishes and how they liked to be supported. Our observations showed the staff team knew people very well. Staff told us how people communicated by using for example, speech, gestures, signs and movement. These details were recorded in people's support plans along with their personal life histories. These provided staff with background information about each person. Relatives told us the staff understood their family member's needs well. One relative said, "(family member's) face lights up when they see the staff." Staff told us they used some pictorial aids to help communication but these were not used routinely.

The staff we met understood the meaning of person centred care and it was evident they saw and treated each person as an individual, respecting their views and wishes. Person centred care means providing care and support which is based on what the person needs and wants.

Staff told us about the importance of respecting people's rights to make choices about their life and to maintain their independence. This we saw as staff supported people with daily tasks and activities. A relative told us the staff helped their family member to be independent. They said, "Yes, staff do everything possible by trying to get (family member) up and about." One relative told us how their family member's independence had improved and how staff respected their family member's decisions about what they wanted to eat.

Staff were respectful in their approach. Staff referred to people by their preferred name and knocked on people's bedroom door before entering. We noted during lunch that on occasions, due to the seating arrangements around the dining room table, staff presented their back to a person. We brought this to the acting manager's attention, as the way people and staff were seated was not always inclusive and could be considered impolite.

Some people used items of equipment to maintain their independence. Staff knew which people needed pieces of equipment to support their independence and made sure this was provided when they needed it.

Relatives were positive about the caring polite nature of the staff. Their comments about the staff included, "Very polite and friendly", "Helpful and caring" and "Excellent." A relative told us the staff provided a good standard of personal care. Likewise another relative told us that the staff approach was not patronising.

Information about advocacy services and supporting people with their rights was available. At the time of our inspection the acting manager informed us no one required an advocate. A relative asked for details of advocacy services and we asked the acting manager to provide this information for them.

People's bedrooms were decorated individually and had personal items.

Relatives told us the staff made them welcome at the home and they could visit at any time.

Good

Is the service responsive?

Our findings

We looked at three people's care files. Their support plans and associated care records provided detailed information about people's health, social background, their preferences, choices and communication. Examples of the records held included; health and social care support plans, a health passport for when a person required hospital treatment, body maps for wound care and information about people's routines and ways of communicating. Staff had guidance documents for people's medical conditions to support staff knowledge.

We saw people's support plans were reviewed regularly and updated following a change to the care provision and where there was input from external health and social care professionals. This was clearly recorded and staff told us they were made fully aware of any change to people's support plans. Staff told us about triggers and behaviours that might indicate a person was feeling unwell and the health observations they would undertake.

People took part in activities which were organised by the staff and also community based events. One person attended a day centre three times a week. Activities tended to be arranged in accordance with how people were feeling on the day. This included music, shopping trips, meals out and formal dinner evenings. Some people went on arranged holidays. A relative told us how pleased they were with the social activities though they were concerned that current staffing levels might affect the time allocated to support people with their social pursuits.

The amount of one-to-one support provided varied from person to person, according to their agreed support package. For a person who needed more support the staff had made every effort to provide this in terms of medical equipment, input from health and social care professionals, on-going GP and district nurse involvement. The staff had responded to the change in the person's condition, as part of monitoring their health and wellbeing.

We looked at the care record files for three people who were living at the home. There was little evidence as to how care plans were discussed with family members. We spoke with relatives about their involvement with their family member's plan of care. Their feedback was mixed at the level of involvement or attendance at care reviews. One relative told us they had not received regular formal updates regarding their family member's care which they had previously requested. Another relative explained to us how they had been fully involved with the staff in respect of medical treatment their family member required. This was recorded in the person's support plan. Relatives said they were pleased with the standard of care and were notified of day-to-day issues but would like to be more involved with care planning and reviews.

We informed the acting manager of this feedback and discussed ways of developing relative input. The acting manager informed us that being new in post they had not as yet conducted formal meetings with relatives. Following the inspection the acting manager informed us individual relative meetings had been arranged to discuss their family member's support plans.

We looked at the provider's complaints procedure which was held electronically. This included timescales for responding to complaints. The complaints procedure was available electronically and in an easy read version. The acting manager told us this was made available to people who lived at the home and relatives. The acting manager said there had been no complaints since the last inspection. We asked relatives if they knew who to speak with if they were worried about anything. They told us they would raise the concern with the service, social services or the safeguarding team. One relative reported however they were unsure who to go to within the service if they were worried, due to the turnover of staff. Another relative said they had raised 'something' informally and it had been dealt with 'speedily'.

Requires improvement

Is the service well-led?

Our findings

On inspection we found there were breaches of regulations in respect of the environment and consent to care and treatment. Although following the inspection we were informed of the actions being taken we were concerned that systems and/or processes to assess the quality of the service were not effective.

The provider did not have effective systems or processes to asses and monitor the service. This was a breach of Regulation 17 (1)(2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager for Royal Mencap Society - 4 The Stables was no longer working at the home at the time of our inspection. The organisation had appointed an experienced internal manager as the new acting manager for the home. The acting manager was aware they needed to apply to the Care Quality Commission (CQC) for the position of registered manager. The acting manager advised us they had been working at the home for approximately four weeks.

We asked the acting manager to tell us about the quality assurance systems in place to monitor performance and improve practice. We were shown an electronic monitoring audit (check) which provided an over view of the home on a monthly basis. The audit was reviewed by the organisation's quality team. This provided information about different aspects of the home, for example, staff training, financial audits, incidents,staff appraisals and performance, care and support records and the environment. A traffic light system was used to identify outstanding issues. The acting manager showed us that some areas of practice required a review such as, staff appraisals, staff performance, health appointments, medication reviews and safety of the environment. We have since been informed of the actions taken to date. For example, dates for performance reviews, DoLS applications submitted to the Local Authority and arrangements to hold individual relative meetings. The acting manager told us they were drawing up an action plan with the organisation's quality team to undertake a full service review. The acting manager was aware of the areas that needed improvement.

We saw there was a system in place to audit people's monies for daily expenditures. This was checked regularly and linked with people's spending plans. The acting manager told us that incidents/accidents were reviewed and actions taken to minimise the risk of re-occurrence. We saw an incident form and the action taken by the staff.

The acting manager had conducted a recent staff meeting. The minutes taken were structured and covered areas such as, staff training, staff rotas and medicines. Staff told us they had handovers to discuss people's support and daily events. Staff told us they received good support from the acting manager. They said the acting manager was approachable and always on the end of phone.

The atmosphere at the service was open and inclusive. We saw many positive interactions between the staff and people they supported. Staff told us they enjoyed working at the home. They told us they were aware of the whistle blowing policy and would not hesitate to use it. Staff said they felt confident in speaking up.

The acting manager informed us that feedback about the service from relatives and people were sought via surveys. This information was not available at the inspection as this was held centrally. Relatives told us they had not attended any joint relative meetings to discuss the overall service. Relatives thought this was a good idea as they would like to be more involved. The acting manager informed us they were going to invite relatives to a 'general' meeting.

The acting manager had difficulty finding a number of documents we requested. The majority were provided on the second day of the inspection or sent to us immediately after the inspection. At the time of our visit the home's policy and procedure file could not be located though we saw policies were held electronically. We were however concerned as information pertaining to the service was not readily available to help assure the delivery of care and safe working. The acting manager informed us they would ensure information was more readily accessible for the staff.

The previous manager had notified CQC (Care Quality Commission) of events and incidents that occurred in the service in accordance with our statutory notifications. The acting manager was aware of this requirement.

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 15 HSCA (RA) Regulations 2014 Premises and equipment A lack of maintenance and management of risks associated with health and safety was a breach of Regulation 15 (1)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Procedures were not in place to obtain valid consent to care and to adhere to the principles of the Mental Capacity Act (2005). This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems or processes to asses and monitor the service were not in place. This was a breach of Regulation 17 (1)(2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.