Walsingham Support Limited

Walsingham Support - 56-58 Turnbull Close

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 02 August 2016. This was an unannounced inspection.

Walsingham Support - 56-58 Turnbull Close is a care home located near Dartford, Kent. The service provides accommodation and personal care to a maximum of 12 people with learning and physical disabilities. At the time we visited there were 11 people living at the service. The people who lived at Walsingham Support - 56-58 Turnbull Close had diverse and complex needs such as learning disabilities, cerebral palsy, epilepsy, severe sight impairment and limited verbal communication abilities.

There was no registered manager at the service during our visit. 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. At the time of our inspection, there were three acting deputy managers. Two were on shift during the inspection.

Premises and equipment had not been properly managed to keep people safe. We found a number of maintenance issues, which had been reported to the provider's head office but repairs had not been carried out.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. There were procedures in place and guidance was clear in relation to Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. However, not all staff had received training in the Mental Capacity Act 2005. Staff had limited awareness of Deprivation of Liberty Safeguards.

Staff had the knowledge and skills to meet people's needs, and attended regular training courses. However, staff training plan showed that staff did not have all the essential training they needed to ensure they understood how to provide effective care, and support for people. There was a gap in the training schedule which showed that staff were not fully equipped to meet people's needs effectively.

Staff had not received regular individual one to one supervision meetings and appraisals as specified in the provider's policy.

Effective systems were not in place to assess and monitor the quality of the service. There were no formal checks in place to ensure that all records were up to date. Care plans and assessments had not been consistently reviewed.

People had access to nutritious food that met their needs. We observed that people were provided with cold and hot drinks when they wanted them. However, we found that eating and drinking guidelines were not always followed by staff.

The systems for the management of medicines were followed by staff and we found that people received their medicines safely. People had good access to health and social care professionals when required. However, staff had not always followed healthcare professional's guidelines.

The service had some risk assessments in place to identify and reduce risks that may be involved when meeting people's needs such as inability to verbally communicate, which could lead to behaviour that challenges and details of how the risks could be reduced. However, as much as having a good understanding of people's difficult behaviours, staff had not always followed stipulated healthcare professionals guidance relating to people's care needs. We have made a recommendation about this.

There were sufficient numbers of staff to meet people's needs. However, the service had been using agency staff to cover 42% staff vacancies. We have made a recommendation about this.

People's care plans contained information about their personal preferences and focussed on individual needs. People and those closest to them were involved in regular reviews to ensure the support provided continued to meet their needs. However, care plans were disjointed with information either not recorded in care plan but recorded in another document. Care plans were not wholly person centred. We have made a recommendation about this.

Staff encouraged people to undertake activities. While some staff spent time engaging people in conversations, some did not. For example, we observed that when staff were putting make up on one person who was severely impaired, there was no interaction or engagement. This in house activity was task oriented and not person centred. Also, some people were observed watching television throughout our visit with little or no engagement from staff. We have made a recommendation about this.

People were protected against the risk of abuse. We observed that people felt safe in the service. Staff recognised the signs of abuse or neglect and what to look out for. Both the acting deputy managers and staff understood their role and responsibilities to report any concerns and were confident in doing so.

Staff meetings took place on a regular basis. Minutes were taken and any actions required were recorded and acted on. People's feedback was sought and used to improve the care.

People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy.

People spoke positively about the way the service was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the acting deputy managers were very approachable and understanding.

During this inspection, we found breaches of regulations relating to fundamental standards of care. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Premises and equipment had not been properly managed to keep people safe.

Although, the provider operated safe recruitment procedures and there were enough staff to meet people's needs, there was a high use of agency staff.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

People received their medicines as prescribed and regular checks were undertaken to ensure safe medicines administration.

Is the service effective?

Inadequate

The service was not effective.

Staff received on-going training in some areas and did not receive adequate training in some other areas.

One to one supervisions were inconsistent and out of date. Appraisal meetings had not taken place.

People's human and legal rights were respected by staff. However, not all staff had received training in the Mental Capacity Act 2005. Staff had limited awareness of Deprivation of Liberty Safeguards.

People had access to nutritious food that met their needs. However, we found that eating and drinking guidelines were not always followed by staff.

People's healthcare needs were not being adequately met because healthcare professional's guidance were not being followed.

Is the service caring?

Good

The service was caring.

There were caring relationships between people and the staff who provided their care and support.

Staff protected people's privacy and dignity, and encouraged them to retain their independence where possible.

People's relatives or legal representatives were invited to participate each time a review of people's care was planned.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were supported in line with their needs. However, care plans were disjointed with information either not recorded in care plan but recorded in another document. Care plans were not person centred.

While some staff spent time engaging people in conversations, some did not. In house activities were task oriented and not person centred.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had no registered manager in post.

There were no effective systems in place to monitor and improve the quality of the service provided.

The service had an open and approachable management team.

Staff told us they found their acting deputy managers to be very supportive and felt able to have open and transparent discussions with them.

Walsingham Support - 56-58 Turnbull Close

Detailed findings

Background to this inspection

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

This inspection took place on 02 August 2016 and was unannounced.

Our inspection team consisted of two inspectors, one specialist advisor who is a specialist in Speech & Language Therapy and one expert-by-experience who carried out telephone interviews with families and relatives. Our expert by experience had knowledge, and understanding of residential services and of supporting family and friends with their health care.

Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

People were not always able to verbally express their experiences of living in the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people and observed care and support in communal areas.

We spoke with four relatives, one family member, six support workers, five agency staff and two acting deputy managers who currently managed the service. We spoke with the operations director who had the overall responsibility for the service, which were different responsibilities to the registered manager and who was a representative of the provider. We also spoke with a visiting healthcare professional and requested information via email from healthcare professionals involved in the service. These included professionals

from the community speech and language therapy team, care managers, continuing healthcare professionals, NHS and the GP.

We observed people's care and support in communal areas throughout our visit, to help us to understand the experiences people had. We looked at the provider's records. These included five people's care records, which included care plans, health care, risk assessments and daily care records. We looked at four staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures.

At our last inspection on 20 May 2014, we had no concerns and there were no breaches of regulation.

Requires Improvement

Is the service safe?

Our findings

People were unable to verbally tell us about their experiences. However, we observed that people felt safe in the service and were at ease with staff.

Relatives told us their family member was safe living at the service. They said their family member had lived at the service for over 20 years and were very happy living there. Comments included, "She is definitely safe there, after all these years", "Yes, she is definitely safe there. We have had no problems at all", "Yes, she is safe. I trust them completely" and "Definitely safe there".

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last three years. The staff we spoke with were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. A member of staff said, "This is to protect people from harm and report abuse. I will inform my line manager immediately". Staff knew who to report to outside of the organisation and gave the example of the local authority and CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. They said, "I would not think twice before reporting bad practice". The service had up to date safeguarding and whistleblowing policies in place that were reviewed regularly. These policies clearly detailed the information and action staff should take, which was in line with expectations. These were pinned to the notice board for staff, visitors and people to access if required.

Staff had a good understanding of people's individual behaviour patterns. Records provided staff with information about people's needs. Through talking with staff, we found they knew people well, and could inform us of how to deal with difficult situations such as behaviours that challenge staff regarding service provision to people. However, as much as having a good understanding of people's difficult behaviours, staff had not always followed stipulated healthcare professionals guidance relating to people's care needs. For example, one who had been identified as showing behaviours that challenge the service care plan was reviewed. It stated that staff should complete behaviour charts ABC charts (Antecedent, Behaviour and Consequences) every time the person displayed behaviour which was considered challenging. "A" refers to the antecedent, or the event or activity that immediately precedes problem behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence, or the event that immediately follows a response. There was no information for staff on how to complete ABC charts and the chart varied in level of detail and appropriate information. On one occasion, staff wrote 'wetting in corridor', with no additional information. This incident was probably distressing for the person, which staff classed as a behaviour incident. Meanwhile the support plan clearly stated risk of occasional incontinence, and there was a care plan for this. This showed that this was not a behavioural issue. In another example in the ABC chart dated February 2016, it stated that the person was "removed from situation and told her behaviour was not acceptable". This approach was not in line with the behaviour plan, and the communication plan, which suggested that the

person would not have understood such a response. These examples showed that staff had not been following stipulated guidance on identifying behaviours that might challenge, addressing such behaviours and recording in the ABC chart. This would have provided a good track of where and when the behaviour occurred to help in identifying any patterns.

We recommend that the provider seeks further guidance on how to adequately complete ABC chart in line with healthcare professional's guidelines in order to meet people's needs.

Within people's support plans we found risk assessments to promote and protect people's safety in a positive way. These included accessing the community, finances and daily routines. These had been developed with input from the individual, family and professionals where required, and explained what the risk was and what to do to protect the individual from harm. We saw they had been reviewed regularly and when circumstances had changed. Staff told us they were aware of people's risk assessments and guidelines in place to support people with identified needs that could put them at risk, such as epilepsy seizures. People had individual care plans that also contained risk assessments which identified risk to people's health, well-being and safety. Guidance was provided to staff on how to manage identified risks. This ensured staff had all the guidance they needed to help people to remain safe.

Premises and equipment had not been properly managed to keep people safe. We found a number of maintenance issues, which had been reported to the provider's head office but repairs had not been carried out. For example, in number 58 Turnbull Close, a toilet seat and door were damaged. This was reported on 11 July 2016 by staff. In number 56 Turnbull Close, a toilet seat was broken. This was reported 04 July 2016. As at our inspection visit, this had not been repaired. This meant that these two toilets had been out of commission for an average of three weeks, which had an impact on service provision in meeting people's needs. Dishwasher in number 58 Turnbull Close had broken down and out of commission for some time. This meant that staff had to wash with hands at every meal.

Healthcare professionals we contacted said, "On several visits from OT (Occupational therapist), it was noted that equipment was not in a functional condition, not clean or had not been maintained. It was not clear if some of this equipment (bath) was being used by residents due to inconsistent information from staff.

Premises and equipment had not been properly managed to keep people safe. This was a breach of Regulation 15 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An acting deputy manager told us there was adequate staffing to meet their needs. Through our observations and discussions with relatives and staff members, we found there were enough staff with the right experience and training to meet the needs of the people who used the service. The records we looked at such as the rotas confirmed this. There were six staff at 08.30 when we started the inspection and at 10am additional four staff joined. Evening, six staff and two wake night overnight were on duty. However, the service had been using agency staff to cover staff shortage. The acting deputy manager confirmed to us that they had 42% of staff vacancies. She said recruitment had been very difficult in the area. Despite this, the provider ensured that shifts were adequately covered by experienced staff. We found that the provider kept training records of agency staff, which confirmed their experiences.

Healthcare professionals we contacted said, 'There has also been evidence of some agency staff not knowing how to interact with residents. For example speech and language therapist has been in the lounge assessing an individual with several other residents also present and observed limited, or no, attempts at interaction with the other residents by agency staff and no other staff present.' We observed this practice

during our visit with two agency staff sitting down with two people watching television throughout our visit with little or no engagement.

A visiting family member said, "Agency staff use phones and listen to music whilst at work. Management haven't been supervising the floor". We observe lack of supervision on the floor while working during our visit. We discussed this during our feedback regarding poor staffing structure in the service. The acting deputy manager told us that they were looking into this.

We recommend that the provider seeks further guidance on recruitment and staffing structures in care homes in order to meet people's needs.

Safe recruitment procedures were followed. Recruitment files were kept centrally at the head office. We requested these to be made available before the inspection ended. They contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with and the staff files that we viewed confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

People were protected from the risks associated with the management of medicines. People were given their medicines in private to ensure confidentiality and appropriate administration. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained to them. We were informed that a trained member of staff administers medicines. The staff member would checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. We found no records of medicine administration errors, which meant that medicines were given safely.

Medicines were kept safe and secure at all times. They were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures obtained when they were removed. We saw records of medicines disposed of and this included individual doses wasted, as they were refused by the person they were prescribed for. This demonstrated that the provider ensured medicines were kept safe.

There was a system of regular audit checks of medication administration records and regular checks of stock. The acting deputy manager conducted the audit of the medicine used. This indicated that the provider had an effective governance system in place to ensure medicines were managed and handled safely.

Each care plan folder contained an individual Personal Emergency Evacuation Plan (PEEP) reviewed in 2015. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was reviewed in February 2016. Fire equipment was checked weekly and emergency lighting monthly. Fire drills took place regularly.

There was a plan staff would use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed

that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies.

Inadequate

Is the service effective?

Our findings

People were unable to verbally describe their experiences. We observed that people had the freedom to move around the service and spend time alone in their rooms as well as in communal areas. People seemed relaxed. We observed staff members responding to people's specific needs in a timely and responsive manner.

Relatives told us that staff are well trained and competent. One person said, "They are very good. We have never had any concerns about them".

We looked at four staff file and found no records that indicated that staff had received induction training, which provided them with essential information about their duties and job roles. Staff training plan sent to us showed that only seven out of 30 named staff had received a kind of induction. The acting deputy manager told us that any new staff would normally shadow experienced staff, and not work on their own until assessed as competent to do so. We spoke with a new member of staff who confirmed this and told us that as part of their induction, they shadowed an experienced member of staff for a week.

Staff were aware of their roles and responsibilities. However, they had not always had the skills, knowledge and experience to support people with learning disabilities. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard.

Staff received annual refresher e-learning training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene. One member of staff told us that they had attended trainings such as infection control, food and nutrition and safeguarding to help them meet people's needs. However, staff training plan showed that staff did not have all the essential training they needed to ensure they understood how to provide safe, effective care, and support for people. No member of staff had received training in equality & diversity, person-centred thinking, risk assessment, support planning, inclusive communication, documentation & record keeping, autism awareness and diabetes awareness. There was a gap in the training schedule which showed that 14 out of 30 staff had not completed epilepsy awareness training needed for the safe and effective support of someone with epilepsy. Some staff had not undertaken epilepsy training despite caring for people who had a diagnosis of epilepsy. Further, only 7 out of 30 staff had completed positive behaviour therapy, which would had enabled adequate support of people with behaviours that might challenge the service. We saw records that evidenced staff were regularly dealing with behaviours that might challenge. Fourteen out of 30 staff were due to renew fire safety course. All these areas were identified as required by the provider in their training plan in other to effectively meet people's needs. This meant that people were at risk because staff may not know how to support their needs.

Only 16 out of 30 staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards

(DoLS) training. Another four were due refresher training. This showed that not all staff had a good understanding of the MCA and DoLS.

Members of staff felt supported by the acting deputy managers, however one to one formal supervisions had not regularly taken place. Two out of four staff files we looked at had no records that one to one supervision had taken place. One staff file showed that their last one to one formal supervision 25 March 2011. Members of staff spoken with told us that if they have any problem, they will speak with the acting deputy manager. One member of staff said, "I think my last supervision was about three months ago". The acting deputy manager confirmed that they had identified gaps in staff supervision and are working on it. The acting deputy manager showed us their plan. The provider's supervision policy stated, 'All employees should have a supervision session at least every 6-8 weeks'. This showed that the provider had not complied with their own procedure regarding staff supervision.

Yearly appraisals had not been carried out. We found no records in two out of four staff files we looked at to show that yearly appraisals were being carried out by the provider. In one staff file, the last record of appraisal was dated 30 April 2013. Appraisals would have enabled staff to improve on their skills and knowledge which would have ensured continued effective delivery of care to people. The provider's policy stated 'Annual performance review should be carried out in person annually for all staff. Annual performance reviews should be completed by the end of April for the annual performance review cycle which runs from 01 April to 31 March'. This showed that the provider had not complied with their own procedure regarding staff supervision.

Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. The acting deputy manager explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People who lived in the service were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The acting deputy manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People had access to nutritious food that met their needs. We observed that people were provided with cold and hot drinks when they wanted them. We observed staff communicating with people as a way of involving them in what they did. The two kitchens of the service were well stocked and included a variety of fresh fruit and vegetables. Food was prepared in a suitably hygienic environment and we saw that good practice was followed in relation to the safe preparation of food. Food was appropriately stored and staff were aware of good food hygiene practices.

However, we found that eating and drinking guidelines were not always followed by staff. Medication chart for one person indicated 'Thick and easy'. During lunch we observed a new member of staff said to the person's visiting mum that "Lunch is almost ready. I am just waiting for the garlic bread". The person's mum then replied, "I'll eat it as she won't manage it". Other care workers indicated "Everyone should know this as it is stated in the plan". But there was nothing in the kitchen for staff to refer to. This clearly showed lack of

knowledge regarding this person's nutrition by some staff. Further, there were discrepancies between the support plan and hospital passport. Support plan for one person stated 'soft moist food/no lumps and fluids through bottle.' Hospital passport which was last updated May 2015 stated 'We have tried thickener but she refuses'.

Nutrition checklist for one person indicated 'problems with swallowing, e.g. leading to choking, 'requires advice from a health professional e.g. SALT, dietician'. We found no evidence of referral to any healthcare professional.

Nutrition/hydration section of the support plan for one person stated 'Once shown meal, staff to cut it into bite-sized pieces. Needs staff support to pace eating, risk of choking. Follow SALT (Speech and Language Therapist) guidelines'. But these were not on file and no indication when last seen by SALT. In all five care records we looked at, they all stated 'refer to SALT guidelines'. However, we found no documentations or guidance from SALT team in people's records. In another example, support plan stated 'Staff must understand her disabilities', but no further information given. 'Ensure healthy diet and that she is supported correctly to eat and drink.' No further guidance for staff on how to support with healthy diet.

Staff had not appropriately adhered with eating and drinking guidelines. Healthcare professional's guidelines had not been fed into support plans. This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff spent time with people to identify what the problem was and sought medical advice from the GP when required. People had a health action plan in place. This outlined specific health needs and how they should be managed.

Records confirmed that staff encouraged people to have regular health checks. People were regularly seen by their treating team. However, staff had not always followed healthcare professional's guidelines. Healthcare professionals contacted said, 'We have found that on occasions advice from healthcare professionals had not been followed and this does have an impact on resident's comfort and safety. For example: requests for monitoring blood oxygen saturation levels with a pulse oximeter 3 x a day was not completed consistently or in a timely manner. Staff were prompted to complete this monitoring. There was a similar experience when staff were asked to monitor posture and document positioning in order to reduce the risk of development of pressure areas. Not communicating important information regarding serious health events such as ambulances being called. Residents were not present when professionals visited as they had been taken out.'

Four out of 11 people living at the service had epilepsy. In one person's support plan, it stated 'A health condition I have is epilepsy'. There was no further information. The psychiatrist's letter from 15 June 2015 stated "It is a long time since you had a fit". There had not been a review of this person's epilepsy health need and there was no epilepsy care plan in place. In another person's file 'My health conditions', it stated 'was born with epilepsy and cerebral palsy.' This was repeated in 'About my health conditions' section but with no further information. No indication of history of epilepsy or current needs, or what are consequences for the person of cerebral palsy. No guidance for staff to manage these conditions. Not all staff had received epilepsy training as stated above. This meant that people's health needs in relation to their epilepsy were not being monitored and managed properly. Adequate measures had not been taken to reduce likelihood of the risk of injury in case of an episode.

Healthcare professional's guidance were not being followed. People's healthcare needs were not being adequately met. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

We observed that staff were kind, considerate and aware of people's individual communication needs. There was a calm and friendly atmosphere. People's bedrooms were decorated to their own tastes.

Relatives told us, "Yes, staff are very kind, caring and patient", "They are brilliant. They have supported her through major surgery and now a broken leg which is in plaster at the moment", "They are excellent…lovely people" and "They are very kind and caring".

Relatives said their family members' privacy was respected. One person said, "When I visit, they always knock on the door before coming in" and "Yes they always make sure the door is closed before they help him".

We observed that staff respected people's privacy. All bedrooms doors were closed. For example, when we arrived, we observed that staff were supporting people with personal care in the privacy of their rooms with doors shut. Staff knocked on doors before they entered. Staff treated people with dignity and respect. Staff were attentive, showed compassion and interacted well with people. The environment was well-designed and supported people's privacy and dignity. People were able to personalise their bedrooms. Staff we spoke with during the inspection demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care for a person. We found the staff team was committed to delivering a service that had compassion and respect for people.

Staff respected confidentiality. People's information was treated confidentially. People's individual care records were stored securely in lockable filing cabinets in the office, but were available to people and staff. We saw evidence that people were asked before information was shared with people.

Staff were kind, caring and patient in their approach. Staff supported people in a calm and relaxed manner. They did not rush and stopped to chat with people, listening, answering questions and showing interest in what they were saying. We observed staff initiating conversations with people in a friendly, sociable manner and not just in relation to what they had to do for them.

Staff knew the people they were supporting well. Some members of staff had worked in the service for about four years or longer. This provided for consistency. The acting deputy manager and staff that we spoke with showed genuine concern for people's wellbeing.

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. Relatives told me they visit as often as possible and keep in touch in between times.

The acting deputy manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the home and who support people to make and communicate their wishes. People told us they were aware of

how to access advocacy support. Advocacy information was on the notice board for people in the service.

Requires Improvement

Is the service responsive?

Our findings

We observed that people were supported to do activities of their choosing. They were not rushed to carry out tasks.

Relatives told us, "Yes we are kept informed about her care plan", "She has a care plan yes, and we are invited to be involved" and "Yes we have regular reviews".

There was evidence that people's needs were assessed prior to admission and continually throughout their stay at the service. The registered manager would normally undertake a thorough assessment of people's needs before accepting them and a structured introduction would take place afterwards. Each person had an initial referral which included a full case history, as well as a pre-admission assessment. The assessment covered all medical, history, any challenging behaviour, and care needed to manage and safely support the person's needs. The assessment was used to determine whether or not the service could meet the person's needs, and if any specialised tools or professional's assistance would be required. This meant that people's needs were assessed in detail to ensure they could be safely supported at the service.

We found that the care plans were disjointed with information either not recorded in care plan but recorded in another document. For example, where information in PEEP stated 'suffers from epilepsy, well controlled with medication so should not pose increased risk.' This was the only information we could find about the status of his epilepsy, there was no specific care plan or anything about this in the care plan. People's care records were not updated to reflect any changes in their needs from healthcare professionals. For example, people were discharged from regular visits by the Speech and Language Therapist with specific guidelines but this had not been reflected in their care/support plan. We discussed our findings with the acting deputy manager. The acting deputy manager told us that the care plans were being reviewed at the time we visited.

We saw evidence that people and their relatives had been involved in making decisions about their care and support and developing their support plans. We reviewed support plans which contained assessments that provided information on how staff should support each person. We noted that changes to the support plans had not been made whenever people had been seen or assessed by external health professionals. For example, changes to support needs following a visit from healthcare professional such as speech and language therapist guidance which were not incorporated into the care/support plan to meet people's daily needs.

We recommend that the provider seeks further guidance on person centred care plans in order to meet people's needs in a person centred way.

People had regular one to one sessions with their key worker to discuss their care and how the person feels about the service. A keyworker is someone who co-ordinates all aspects of a person's care at the service. These sessions were documented in the person's support plan. We saw monthly key worker reports up to May 2016. This recorded activities in house and external, and trips out when done. Key worker set goal of regular arrangement for the person's contact with parents, achieved with fortnightly calls at regular time

when key worker was on duty to support, by agreement with the parents. There was a monthly key worker's checklist to track person's appointments, activities, toiletries, clothes. Although this was last documented in May 2016, it showed good practice regarding involving people in their own care.

The acting deputy manager explained the kind of activities that are organised for people in the service. These included trips out, swimming, reflexology, hydrotherapy, pampering day and encouraging people to stay in touch with their families. They explained that they tried to engage with all the people living in the service, but that some people were more difficult to motivate than others. Staff had time to spend with some people who prefer not to take part in group activities. We were told that they do record the activities that each person joined in in the daily record, which we confirmed. While we inspected, some people went out for swimming, while the ladies had their nails painted as part of the pampering session. However, we observed that when staff were putting make up on one person who was severely impaired, there was no interaction or engagement. The activity was task oriented and not person centred.

However, we observed that two people watch television throughout our visit. Asked staff why they were not engaged otherwise or why there were no activities for them. We were told that one male staff was allocated to decide the activity on the day and the staff chose watching a film on television, which they sat down to watch too. A relative spoken with said staff often put their daughter in front of the TV which she does not watch or like. This showed that the activity was not person centred or based on the people's likes and preference.

Further, we observed poor practice from members of staff regarding how they involve people in their care. For example, one member of staff came into the living room while three people were watching a film on the television and said "The film being watched is too explicit. Let us change it". She asked one person who was mobile and unable to verbally communicate but did not ask or communicate with the other two people seated in the wheelchair if they wanted to watch the current film or not. She went ahead and changed the film to another film which we found was inappropriate for people's age and left. She did not ask about their preferences or choice. We discussed this with both the acting deputy managers and the operations director. Both said that they have been addressing staff practice regularly.

We recommend that the provider seeks further guidance on how to involve and engage people in a person centred way in their care/support in order to meet people's needs

The provider sought people's and others views by using annual questionnaires to people living in the service, staff, health and social care professionals and relatives to gain feedback on the quality of the service. The completed surveys were evaluated and the results were used to inform improvement plans for the development of the service. The last questionnaire sent out and received were in November 2015 and feedback was generally good. For example, on the question of 'Overall, how happy are you with the support you get? 100% said they were happy.

The provider had a comprehensive complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was on display within the foyer of the service and this was also available in an easy read format to support the communication needs of people. The policy included information about other organisations that could be approached if someone wished to raise a concern outside of the service such as the local government ombudsman. We saw record of one complaint since our last visit. Concern was raised by a family member about their son's care plan that requires updating. This was responded to immediately and we saw that the action of updating care plans was on going when we visited.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager at the service during our inspection. The service had three acting deputy managers who fulfilled the role of a registered manager. We met the operations director who told us that they had recently recruited a new manager who would be starting once all checks had been completed.

Relatives told us, "A new manager has been recruited and 'X' (Acting deputy manager) has been brilliant in the interim. She has coped with staff changes" and "It would help if they (staff) introduced themselves when I visit. I am partially sighted so don't know who I am speaking to".

Healthcare professionals commented, 'Management has changed frequently over the last year and it is not clear who can be contacted. There was evidence of poor communication about health and social needs. Sometimes staff could not locate documents regarding visits from other services (i.e. Dietician) when requested and stated appointments were not put in the diary.'

Staff told us that they felt comfortable and confident in raising concerns with the acting deputy managers. One member of staff said, "I can talk to managers. They are approachable. They do support us". Agency staff said, "Management is very good compared to other homes I have worked" and another staff said, "Yes, I get support from management team. They get involved. You can speak to them".

The management team encouraged a culture of openness and transparency. Their values included 'Put people at the heart of everything we do, Seek continuous improvement in quality, staff development and service delivery, Are always open and honest and do what we say we will do, Treat everyone with respect and act on their feedback. Staff told us that an honest culture existed and they were free to make suggestions, raise concerns, drive improvement and that the acting deputy managers were supportive to them. Staff told us that the acting deputy managers had an 'open door' policy which meant that staff could speak to them if they wished to do so. We observed this practice during our inspection.

Staff told us the morale was good and that they were kept informed about matters that affected the service. They told us that team meetings took place regularly and they were encouraged to share their views. They found that suggestions were warmly welcomed and used to assist them constantly review and improve the service. Staff meeting records confirmed that staff views were sought.

Records were not always clear and robust. Records relating to people's care and the management of the service were not consistent and can be confusing. It was not always clear from the records if and when a healthcare professional's guidance or recommendations had been implemented. For example, we found no guidance for staff relating to the completion of ABC chart for monitoring people's behaviour in care records. There were no care plans for epilepsy and in some cases we found no risk assessment in the care plan. We found no records of behavioural guidelines and no appropriate risk assessments. There was no guidance for staff around signs to look out for if the person may be deteriorating. ABC charts were not consistently completed. No records of staff induction in some staff files.

Audit systems were not in place to monitor the quality of care and support. Although we found a 'Building maintenance audits check', this was not robust enough to ensure maintenance is carried out regularly. We also found that the service carried out medication audits. However, we found that medicine profile for one person was last reviewed on 05 May 2015. Care plans, staff files and risk assessments were not being audited. Reviews of people's care plans were inconsistent and there was no established system in place to ensure that people's care plans remained up to date. For example, in one person's care records, we found that 'Behaviour analysis & positive support plan' for one person was last reviewed in May 2015, which was over a year. Another person's communication profile was last reviewed in 10 February 2015. Robust audits of documentations would have identified all issues we found above.

The examples above demonstrate that the provider failed to operate an effective quality assurance system and failed to maintain accurate records. This is a breach of Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

The provider told us that they had accreditation schemes with Skills for Care's National Minimum Data Set for Social Care (NMDS-SC), which is an online database which holds data on the adult social care workforce. The provider used this system to update information on staff training regularly. This helps authorities to plan resources for the local workforce and commissioning services. However, there were still identified gaps in staff training records as identified above.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team.

The acting deputy managers were aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the acting deputy managers understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Healthcare professional's guidance were not being followed. People's healthcare needs were not being adequately met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Staff had not appropriately adhered with eating and drinking guidelines. Healthcare professional's guidelines had not been fed into support plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment had not been properly managed to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate an effective quality assurance system and failed to maintain accurate records.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.