Honeybourne House Limited

Cameroon

Inspection report

Heath Cross
Whitestone
Exeter
EX4 2HR
Tel: 01647 61018
Website: www.alliedcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place over two days, 4 August 2015 and 7 August 2015. Both visits were unannounced.

The service was previously inspected on 1 May 2014. No concerns were identified with the care being provided to people at that inspection.

There was a manager in place, although they were not yet registered. An application to register the manager had been received by the Commission and was being processed at the time of this inspection. 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.

There were eight people with learning disabilities living at Cameroon at the time of our inspection. People had varying communication abilities. We either spoke with people or observed people in communal areas to find out about their experiences of daily life at Cameroon.

There were enough staff to meet people's needs and to care for them safely. However, many of the staff were

Summary of findings

agency staff who had been recruited on a short term temporary basis from overseas. They were in the process of recruiting new permanent staff to replace the temporary staff. This meant the home was going through a period of change that was at times difficult for both staff and the people living there..

Staff had been given information on how to communicate with people and they were able to explain non-verbal communication methods. However, there was a risk of increased communication barriers for those staff whose first language was not English. Staff did not always seek consent before providing care, or giving people information or explanation about the care or support being provided.

Where people lacked the mental capacity to make certain decisions about their care and welfare the service knew how to protect people's rights. However, where people's liberty was restricted the processes to protect people's legal rights had not been fully implemented, although the provider had recongised this and was taking action .

All staff had received induction and regular updates on all essential health and safety related topics. However, insufficient training had been provided on topics relevant to the health and personal care needs of the people who lived there such as autism, epilepsy or dementia.

People were protected from the risk of abuse and avoidable harm through appropriate policies, procedures and staff training. This included procedures to protect people from the risk of financial abuse. People who were able to communicate verbally told us they felt safe and knew who to speak with if they were worried or upset. Risk assessments had been regularly reviewed and updated and information was given to staff on how to reduce those risks.

People had been consulted and involved in drawing up a plan of their care. People received support with personal and health needs in line with their individual care and support plans. Most areas of the care plans had been reviewed at least every three months and updated where necessary. However, social needs had not been reviewed or updated and this meant there was a risk that people did not receive the support they needed to lead an active or fulfilling life.

People had regular health checks and the service received good support from a range of healthcare professionals. Those people who were able to speak with us told us they were happy living there. Comments included "I like living here." and "Yes, I am happy here." We also saw people were relaxed and happy and responded to staff approaches with smiles.

Medicines were stored and administered safely. Only staff who have been trained and assessed as competent were allowed to administer medicines. Most records were completed efficiently and there were systems of balances and checks to make sure safe administration procedures were followed. However, records of prescribed creams and lotions had not always been completed to show they had been applied correctly.

The provider had systems in place to monitor the quality of the service and identify any areas where improvements were necessary. The quality assurance systems had already identified many of the issues we found during this inspection, for example the need to submit DOLS applications for those people whose liberty may be restricted. Measures had been put in place to address the issues, although these had not been completed at the time of this inspection.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not fully safe.

People's medicines were not always managed safely. There was a risk creams and lotions may not be administered as prescribed. Systems to ensure prescribed medicines were discarded when no longer safe to use were not fully effective.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to lead fulfilling lives and remain safe.

There were sufficient numbers of suitably trained staff to keep people safe and meet each person's individual needs.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff had not received adequate training or qualifications in topics relevant to the needs of people with complex communication and support needs.

The service did not always act in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

People were supported to access specialist healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect. The staff and management were caring and considerate.

Staff understood each person's verbal and non-verbal means of communicating their choices and preferences.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People were involved as much as possible in the assessment and planning of their care. However, some areas of the care needs had not been reviewed regularly and there was a risk some information may be out of date.

People were not fully supported to lead active and fulfilling lives that met their assessed social needs.

Summary of findings

Is the service well-led?

The service was not fully well led. The provider had systems in place for monitoring the quality of services for people. Whilst they had identified areas for improvement they were not fully implemented at the time of the inspection.

There was a clear staffing structure in place with clear lines of reporting and accountability

People, relatives and staff were encouraged to express their views and the service responded appropriately to their feedback.

People were supported to maintain family relationships although a lack of transport at times meant there was a risk of social isolation.

There were sufficient numbers of staff to keep people safe and meet each person's individual needs.

Requires Improvement

Cameroon

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 unannounced inspection was carried out by one inspector and took place on 2 and 7 August 2015. The service was previously inspected on 1 May 2014 when it was found to be fully compliant. There were eight people living at Cameroon at the time of our visit.

Before the inspection we looked at information we had received about the service since the last inspection. This included notifications and information from staff and professionals who knew the service.

During our visit we spoke with, or observed the care provided to each person who lived there. We spoke with three staff, the manager and deputy area manager. We reviewed records of care including four care plans, daily reports and records of medicines administered to people. We also looked at staff recruitment, training and supervision records, and records relating to the maintenance and safety of the home and quality assurance.

Requires Improvement

Is the service safe?

Our findings

Whilst we found some good medicine practices we also found areas for improvement. People's medicines were administered by staff who had been trained to administer medicines. The manager told us they only allowed staff who had completed training and had full competency assessments to administer medication. Medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. Two staff administered medicines to ensure medicines were doubled checked and correct before being administered.

Each person had a secure medicine cabinet in their room. At the time of this inspection there were no people who self-administered their own medicines and therefore the medicine cabinets were used to store creams and lotions. We saw some unexplained gaps in the medicine administration records for prescribed creams. The deputy manager told us they were confident the creams had been applied, however there were no records to show they had checked the records and identified the unexplained gaps. They had not checked with the staff responsible to find out why the administration records had not been completed, or to check that the creams had been applied as prescribed. The lack of recorded information about when these creams were applied meant they were unable to monitor the effectiveness of the creams.

Creams and lotions had been dated when opened. However, we found some creams and lotions had not been discarded within the recommended date. This could potentially mean people received creams and lotions that were not fully effective because they were out of date. The deputy manager showed us information on the recommended date for disposal that was available to all staff and after discussion they had misinterpreted some areas of the guidance. Although creams and lotions were not being disposed in line with this guidance the level of risk was low because they had only exceeded the recommended disposal date by relatively short periods of a few days.

All prescribed medicines including controlled drugs were stored securely. The home used a blister pack system with printed medication administration records. Blister packs and most medicines used each day were stored in a medicines trolley that was locked and secured when not in use.

Where people were prescribed medicines to be taken on an 'as required' basis detailed guidance was seen in their care records explaining when staff should offer these. We also saw consent to medication forms had been completed showing that people's capacity to consent to medication had been assessed.

Ten staff had received training on administration of emergency rescue medication for people who had severe epilepsy. There was clear guidance and safe procedures in place to make sure people who had epilepsy were accompanied by suitably trained staff and their medication went with them whenever they went out.

People who were able to communicate verbally told us they liked living at Cameroon and felt safe. They were confident they could speak out if they were worried or upset. They knew who to speak with and they were confident managers and staff would listen to their concerns and take action. Comments included "I like living here. I don't want to move anymore" and "Yes, I am happy here." People who were unable to communicate verbally looked relaxed and happy.

Staff told us they had received training and information on safeguarding and they were confident any concerns raised with the management team would be listened to and acted upon. They gave us an example of a concern that had been raised with the manager and the action that had been taken to address the concern appropriately. Where allegations or concerns had been bought to the manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected. One member of staff told us "I am confident the management really care about the people here." We were given a copy of the staff training matrix which confirmed staff had received training on safeguarding. The manager told us staff had received computer based and classroom based safeguarding training. Refresher training was booked for September 2015 for those staff who needed updating in this topic.

There were sufficient staff on duty at the time of our inspection to meet the needs of people safely. On the first day of our inspection there were four care workers and two

Requires Improvement

Is the service safe?

managers on duty supporting eight people. The care workers were responsible for cooking and most cleaning and laundry tasks, although a cleaner was employed three days per week to clean the communal areas. Gardeners and maintenance people were also employed when required. On the second day there were three staff plus the deputy manager on duty. We were told that a member of staff was unexpectedly off sick and they had been unable to cover their shift at such short notice. Despite being one member of staff short on the second day routines were carried out effectively. We also saw staff had time to sit with people and support them with their individual activities and interests.

At the time of this inspection there were 16 staff employed. Many of the staff had been recruited from overseas through a recruitment agency. Risks of abuse to people were minimised because the provider made sure that all new staff were thoroughly checked to make sure they were suitable to work at the home. We looked at five staff files which contained references and checks completed before new staff began work. The files contained evidence that showed the staff were safe to work with vulnerable adults.

Risks to each person's health and safety had been assessed and reviewed regularly to make sure people received care safely. These included activities inside and outside of the home such as access to the community, and access to the kitchen. Personal care tasks covered activities such as bathing and explained risks associated with each task. Health risks included choking, moving and handling, falls, and catheter care. Each risk assessment provided detailed information about the measures to be followed to minimise the risks. Staff were asked to sign each risk assessment every time they were reviewed to say they had read them and understood the instructions to be followed in each risk assessment document.

People were supported to do the things they wanted to do even where there were identified risks. Measures to reduce the risks had been put in place where possible. For example, one person enjoyed going out for a walk on their own in the lanes around the home. Staff knew the person's usual route and made sure the person always wore reflective clothing. They explained the actions they would take if the person did not return home at the expected time.

Where people were at risk of choking there was information in their care plans explaining the actions staff should take when supporting the person to minimise the risks, including any cutlery or plates to be used to help the person eat safely. Guidance had been provided by the Speech and Language Therapy (SALT) team. Laminated information was displayed clearly in the kitchen on the foods people could eat safely and those to be avoided.

Where people were at risk of falls their needs had been reviewed and specialist medical advice and assessment had been requested. One person who had fallen recently had received input from an occupational therapist who had provided advice and specialist equipment.

People who were unable to hold or manage their own money could be confident there were systems in place to make sure their money was managed and held safely. Where people had families or representatives who could look after their income and savings there were systems in place to make sure people had cash available at all times for day to day spending needs. All purchases and transactions were recorded and balances were checked and closely monitored. For those people who had no relatives, advocates or representatives to support them with their money the provider had safe systems in place to manage their income, savings and day to day spending needs. Best interest procedures involving care managers and family were followed before any large purchases were agreed on behalf of people who were unable to make decisions about important matters that affected them.

The building and equipment were safely maintained. There were plans in place to address areas both inside and outside the home that were showing signs of wear and we were assured this work would be completed in the very near future. All equipment including fire safety and electrical equipment was regularly checked and serviced.

We recommend the provider ensures staff follows guidance provided by nationally recognised sources of good practice such as the Royal Pharmaceutical Society on safe recording and disposal of medicines including prescribed creams and lotions.

Requires Improvement

Is the service effective?

Our findings

People were not supported by staff with the skills or experience to meet their needs fully. Many of the staff had been employed on a short term, temporary basis through an agency specialising in recruitment from other countries. The training records showed all of the staff had received induction training covering all essential health and safety related topics. However, the staff team had received very little training on topics relevant to each person's health and personal care needs. For example, only five staff had received training in the past on autism and Asperger's. Five staff had received training on dementia and seven staff had received training on communication including Makaton. Some of the training had taken place several years ago. This meant there was a risk that some shifts were covered by staff with insufficient experience, skills or knowledge to meet each person's needs safely.

Updated training had been planned for 2015 but this training had not been provided at the time of this inspection. The manager told us he was aware some staff had not received training on topics relevant to people's needs. After the inspection we were given assurances that staff would be receiving training on a range of relevant topics in the near future.

We were told three new staff were in the process of being recruited and were expected to start in the near future. They hoped to recruit further permanent staff to replace all temporary staff. This will enable them to provide comprehensive training to all permanent staff in future.

Staff who had been recruited from overseas did not always have fluent English language skills. At times we observed some staff did not communicate clearly with people while providing support. This meant there was a risk this may cause some people increased barriers to effective communication with staff. We asked one member of staff if they had received support or training to help them improve their English language skills. They told us they had sourced and funded their own training. We discussed English language training with the manager. He confirmed training in this topic had not been provided, although new staff recruited from overseas had been given information on relevant English language courses they could attend if they wished.

The training matrix showed that three staff held a relevant professional qualification. This is below the national average and demonstrates a low level of suitably qualified staff. Two further staff were in the process of obtaining a nationally recognised professional qualifications.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training in the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, the service did not fully comply with the MCA code of practice to protect people's human rights. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time.

People's capacity to make informed decisions and to consent to care was assessed and there was evidence in the care plans to support this. Although we saw and heard evidence to show that most staff sought people's consent before providing care, this was not always the case. Two staff described how they gave people choices and understood each person's verbal and non-verbal responses. For example, they explained how one person responded by blinking, making a noise, or turning their head away in response to questions to indicate their agreement or disagreement. This was also clearly explained in the person's care plan. However, we also saw staff assisting the person to move from their chair to a wheelchair without seeking consent or explaining what they were about to do.

We spoke with the manager who told us all staff had been given training and instruction on seeking consent and communicating with people clearly when carrying out any personal care tasks. We also discussed the possibility that there may be language barriers between overseas staff and people with communication difficulties and this may result in staff providing care without first seeking consent. The manager assured us they would follow this up and consider any further actions such as any training that may be necessary.

Care plans contained information about restrictive practices such as the use of bed rails and lap belts for wheelchairs and lounge chairs. Assessments had been completed which referred to multi-disciplinary best interest agreements. However this was not fully evidenced because

Requires Improvement

Is the service effective?

the names of people who had been involved in the multi-disciplinary decisions had not been recorded. The manager told us the evidence may have been archived but they were unsure where this was held. The restrictions had not been reviewed regularly and had been in place for more than a year. The manager assured us they would arrange reviews to be carried out and to seek best interest decisions for these restrictions.

The manager told us they were aware of the need to submit applications for those people whose liberty had been restricted, but they had not submitted these at the time of this inspection. They gave assurances that the applications would be completed in the very near future. Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people lacked capacity to consent we were given verbal assurances that multi-disciplinary best interest decisions had been sought. For example, staff explained that one person needed blood tests to be taken but they were scared of injections. They had sought agreement and advice on how to support the person to overcome their fear of injections, and they were following this advice which was slowly bringing about positive changes. This was clearly evidenced in the person's care plan.

The daily menu was displayed on a large notice board in the dining room. The menu board used pictures as well as text showing the meals on offer that day. People were consulted and involved in choosing the menus using the pictures to help them choose. In addition to the main meals on offer the menu board included pictures showing the alternatives people could request, such as jacket potatoes. A printed menu displayed in the kitchen showed people were offered a varied and balanced diet.

People told us they enjoyed the meals and were always given an alternative if they did not want the foods offered on the menu. For example, one person told us they liked fish but did not like chips. Instead they chose boiled potatoes with their fish. They also told us they could ask for anything else they wanted, for example jacket potatoes or pies. One person said they particularly liked Indian food and staff often made this especially for them.

One person's care plan identified their health was at risk due to their weight. There was no further information or guidance in the care plan about a suitable diet to follow or portion sizes. However, staff were aware of the person's dietary needs and they were confident the person received a suitable diet. The deputy manager told us they will amend the care plan to include this information.

One person told us they really liked home-made pies such as steak and kidney pies. They also said they remembered foods they used to have when they were younger such as apple dumplings and home-made crab apple jelly. We asked the staff how much of the food was home-made and they said that most of the main meals were home-made, but they were limited by the cooking skills of the staff team. They had tried to recruit a cook but so far had been unsuccessful. They hoped that if they could recruit a skilled cook more foods such as traditional pies and puddings could be home-made.

The property is a bungalow with level access from the dining room and kitchen to people's bedrooms. The lounge is on a lower level and a ramp has been put in place to enable people who use wheelchairs to access this room. There are also ramped areas outside the home to enable people to reach most garden areas safely. There was also a sensory room with a range of lighting and sensory equipment and we were told several people enjoyed using this room. At the time of our inspection the room was not in use as it had developed an odour problem but the manager told us they had requested the maintenance team investigate the source and take action to address it.

Staff told us they were well supported. They received individual supervision every six weeks. Staff meetings were held regularly and this was an opportunity for staff to share good practice and to voice their opinions. Minutes of the meetings had been recorded and these included action plans to address issues raised.

Good

Is the service caring?

Our findings

Staff were caring. We asked one person if the staff were kind and they said "yes they are kind." They talked about the staff they liked and described one member of staff they were particularly fond of, saying "She is not bossy – she is my best friend." Another person said "Yes, they are all nice."

Care plans included information and instructions to staff about how to consult and involve people. For example, one care plan said "I like to choose what I do within my days as I sometimes change them." We spoke with the person about their care plan and asked them if they had been involved in drawing it up. They confirmed they had been consulted and the information was correct. They told us they often changed their mind, and this was not a problem because staff understood this and supported them. Staff we spoke with explained how they supported the person to make decisions about their daily life. They spoke of people with fondness, caring and understanding of each person's individual personality, preferences and needs.

Staff understood the things that made people happy. One staff told us they shared good practice, observations and ideas with other staff. For example, a person who was unable to communicate verbally did not appear to enjoy group activities or interaction with other people. However, the person sometimes chose to sit next to staff and the staff member had found they responded positively and appeared much calmer and happier when they stroked the person's hair gently. They also described how the person loved going out on car trips and described their facial expressions that showed the person was happy and relaxed.

People's needs and personalities were understood by staff. A member of staff described how they offered people choices, including people with communication difficulties. They described how they stayed close to people and observed their verbal and non-verbal responses. They told us their induction included training on offering choice. They said they had been given instruction to offer choices such as "Do you want…?" and offering alternatives. They also explained the non-verbal responses for some people and talked with compassion about their determination to provide the right support for each person. For example in the past one person always sat quietly in their chair all day without communication with staff. The person's communication had improved significantly after staff had spent one-to-one time speaking with them. They described how the person had gradually begun to make sounds and some recognisable words. The person now enjoyed singing songs with staff for example "Daisy, daisy".

People received care at the end of their lives from staff who were caring and compassionate. Staff explained how they had communicated with a range of health professionals and followed training and instructions on how to meet the needs of people when they became seriously ill. This had at times been demanding and difficult and it was evident the staff had cared for each person deeply. They spoke about their wishes to support people to remain at Cameroon for as long as possible when they were nearing the end of their lives. Staff understood the importance of enabling people to remain in familiar surroundings with staff who understood their needs. They also recognised their limitations when people's illnesses became so complex that they needed to be hospitalised. Staff had received compliments from a social worker who had praised them for the way they had engaged with a range of professionals at the end of a person's life. A health professional also praised the staff for the "Excellent care (the person) received at Cameroon."

Requires Improvement

Is the service responsive?

Our findings

People did not receive sufficient support from staff to enable them to lead active or fulfilling lives, although we saw evidence to show this was being addressed. People's individual social needs had not been assessed regularly and there were no plans in place to show how these would be met. While most sections in the care plans had been reviewed and updated some information was out of date. Information about each person's interests was out of date. For example one person had said in 2012 they would love to go abroad in the next few years. They had not achieved this, and there was no evidence to show this plan had been reviewed. Staff told us they were in the process of planning holidays for those people who wanted to go away, for example one person was going to Brighton in the near future.

Activities were offered on an 'ad hoc' basis. On the first day of our inspection we saw people sitting in the lounge and dining room while staff were busy with other daily routines such as cleaning and cooking. One person regularly went out on their own for walks in the lanes around the home but otherwise we saw people did very little during the day. People were not encouraged to help staff with daily routines.

We asked staff how they supported people to lead active lives. They told us that in recent months their priority had been caring for two people who had been seriously ill. This left very little time to support other people with planned outings or activities. In recent weeks the situation had become easier and staff had more time once again to provide activities. However, they no longer had routines or systems in place to make sure people received the individual or group support to meet their social needs. The manager told us they were in the process of recruiting new staff who had been chosen for their skills and experience in supporting people to lead active and fulfilling lives. They planned to update the care plans and put systems in place to make sure all individual social needs would be met in future.

On the second day of our inspection we saw improvements in the level of activities were beginning to be put in place. Staff were sitting with people chatting and supporting them in a range of activities such as games, jigsaws, arts and crafts, and quizzes. There was a lively atmosphere and people were smiling and enjoying the activities and interaction with staff. One person told us they liked cooking and wanted to start doing some cooking again. A member of staff agreed and said they could help cook the evening meal that day. We also saw evidence of 'pampering' sessions for women where they had their hair and nails done.

People had been consulted and involved in drawing up their own personalised care plan. The plans had been drawn up using photographs, signs and symbols as well as text to enable people to be involved and consulted in their care planning process. The care plan of a person with poor eyesight included large yellow text because staff were aware that yellow was a good colour for people with visual impairment. Other care plans contained photographs of the things they liked doing and the places they liked to go to.

Care plans provided good information to staff about each person's daily routines and preferences. For example one care plan explained the person usually woke up around 8am and this was when staff should offer their morning medications. However, from time to time their routine changed and sometimes they liked a lie-in until lunchtime. The care plan instructed staff to respect the person's right to choose their own daily routine.

We showed two people their care plan files. One person confirmed they had been involved in drawing up and reviewing their care plan, and they told us the information was correct. Another person's care plan explained in detail their non-verbal communication methods. We showed them their care plan and saw their responses could easily be recognised and understood from the information contained in their care plans.

Staff responded to people's changing needs. For example, one person wore specially made boots that provided support when walking. The boots had become worn and no longer provided effective support. A member of staff described how they had repeatedly requested an appointment for the person to be fitted with new boots. They expressed frustration with the slow response from the relevant health service but also showed a determination to follow this up regularly until an appointment was confirmed.

Every person had recently been consulted about plans to redecorate their bedrooms. This was planned to be completed in the near future. One person told us they

Requires Improvement

Is the service responsive?

sometimes had meetings where they were asked for their views on matters relating to the home and daily life. They confirmed the staff had asked for their views on the decorations and maintenance both inside and outside the home.

We looked around the home and found each person's bedroom had been personalised to suit their individual tastes and preferences. One person showed us their room with pride and talked about how they had chosen each item.

We recommend the provider seeks appropriate guidance regarding involving people in their care and records.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place for monitoring the quality of services for people. Whilst they had identified areas for improvement they were not fully implemented at the time of the inspection.

The service had a manager in post who was not yet registered. An application had been received by the Commission for their registration and this was being processed at the time of this inspection

There was a clear staffing structure in place with clear lines of reporting and accountability. The registered manager and deputy supervised the care staff. The manager was supported by an area manager and deputy area manager who visited the service regularly and carried out monitoring checks to make sure the service was running smoothly. The provider also employed a quality assurance manager who also visited the service from time to time to ensure people received a good quality of service. Their checks included speaking with people who lived there and with staff to make sure people were happy and well supported.

Some staff told us they could ask for support or advice from the manager at any time. We saw evidence in staff meeting minutes where staff had been asked for suggestions for ways in which management support could be changed or improved.

The provider was aware of problems and concerns in the service and had taken measures to address these. We heard some unease expressed by staff about relationships and friendships between the management team and staff. There was also a sense of division between temporary and permanent staff. This meant some staff felt less able to raise concerns or ask for support because they feared their jobs may be at risk. The deputy area manager told us staff had been given contact numbers for other people within the organisation they could speak with in confidence if they had any concerns they felt unable to raise with the manager or deputy manager. They also made sure staff and people living in the home had regular opportunities to speak with other members of the senior management team when they visited the home. They were confident that problems within the staff team will be addressed when they finally manage to achieve a full staff team of permanently employed staff. This will also enable them to make sure all staff have the training, knowledge and experience necessary to meet people's needs fully.

The manager and deputy manager followed monitoring systems to ensure daily routines were carried out. Daily reports were completed by staff hourly throughout the day for each person. These included meals eaten, activities, health, mood, and appointments. The reports explained the tasks completed by staff. The reports were reviewed by the manager or deputy manager each week to ensure people's needs were being met appropriately. Medications were also monitored and checked on a monthly basis, although these checks had not been fully effective as the checks had not identified gaps in the medication records for prescribed creams and lotions. .

Monitoring systems were also in place by the provider to regularly check the service was operating effectively. Senior managers visited the home at least monthly and completed monitoring reports. These monitoring systems had identified most areas we had found during this inspection, such as failure to submit DOLS applications promptly to meet changes in legislation and good practice guidance. They had plans in place to address the issues. They had taken a range of measures to improve their recruitment of new staff.

The manager has notified the Care Quality Commission and other relevant authorities of any accidents or incidents and has taken appropriate steps to reduce the risk of further occurrences.

People were involved and consulted about daily routines and the management of the home through resident's meetings, and through questionnaires. The questionnaires had been evaluated, although there were no formal action plans drawn up to address any negative issues. However, the manager was able to explain the actions they had taken to address the issues.

Questionnaires were also sent to relatives, friends and advocates and their responses had been collated. People told us they were supported to keep in contact with friends and relatives. For example, one person talked about visits to see their sister, and told us staff helped them to keep in touch for example by making telephone calls and sending birthday and Christmas cards.

Requires Improvement

Is the service well-led?

Opportunities for people to go out and be involved in the local community were limited at the time of this inspection due to lack of transport and lack of staff who were able to drive. We were told the home's minibus had been in the garage waiting for repair for three weeks. No alternative transport had been provided in the meantime. The home is in a rural area with no regular public transport nearby. On the second day of our inspection we were told the minibus repairs were expected to be completed in the next few days and they expected people would once again be able to go out regularly when the repairs were completed. We heard about shopping trips that had been planned. We also heard about involvement with local churches and community events for those people who wanted to participate. Some people regularly attended local clubs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment must only be provided with the consent of the relevant person. Discussions about consent must be held in a way that meets each person's communication needs. Information must be given to people about the care and treatment that is being offered. Where people lack capacity to consent to their care or treatment the provider has failed to follow a best interest process in accordance with the Mental Capacity Act 2005, including the use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards where appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The training, learning and development needs of staff had not been fully met. People did not receive support from suitably qualified, competent or skilled staff who had the knowledge or training to meet each person's individual needs fully.