Isle of Wight Council

The Gouldings

Inspection report

The Gouldings
St Andrews Way
Freshwater
Isle of Wight
PO40 9NH

Tel: 01983752135
Website: www.iwight.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: The Gouldings is a local authority owned service which provides both a short stay residential respite and re-enablement service, day care service and a community re-enablement service including personal care for people living in their own homes. People in residential care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection 15 people were receiving a residential based service and 45 were receiving a community based service.

People's experience of using this service:

● People told us they felt safe when they were receiving a residential or community based service from The Gouldings. However, we found improvement was needed to ensure medicines were managed in accordance with best practice guidance, manage some individual risks to people and to ensure staff received all necessary training to safely undertake the roles they were employed for.

● Quality assurance processes were not always effective. They had not identified concerns we found during the inspection, relating to the management of medicines, infection control, risk management and training for staff. Care plans did not always reflect the care people had received and fluid intake records were not effectively identifying when people may not have received enough to drink.

● People's needs were met in a personalised way by staff who were kind and caring. Independence was promoted.

● People's rights and freedoms were upheld. Staff acted in the best interests of the people they supported.

● People were empowered to make their own choices and decisions. They were involved in the development of their development of care plans designed to promote people's recovery and independence (re-enablement) care plans.

● People felt listened to and knew how to raise concerns. They, and healthcare professionals told us they would recommend the service to others.

● Staff respected people's privacy and protected their dignity.

● The residential service environment was safe and suitable for people staying there. There was with an ongoing refurbishment programme.

The service has been rated Requires Improvement as it met the characteristics for this rating in three of the five key questions. More information is in the full report, which is on the CQC website at: www.cqc.org.uk

Rating at last inspection: The service was rated as Good at the last full comprehensive inspection, the report for which was published in September 2016.

Why we inspected: This was a planned inspection based on the previous inspection rating.

Enforcement: We have told the provider they must ensure medicines are managed safely and all risks to

people are assessed and action taken to mitigate these risks. Staff must receive all necessary training to safely undertake their roles. For full details please refer to end of full report.

Follow up: We will continue our routine monitoring of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

The Gouldings

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was completed by two inspectors and two experts by experience in the care of older people. One expert by experience made telephone calls to people to gain their views about the service and the second spoke with people within the residential part of the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: The Goulding's is a local authority owned service which provides a short stay residential respite and rehabilitation service, a day care service and a community re-enablement service, including personal care for people living in their own homes. People in residential care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection 15 people were receiving a residential based service and 45 were receiving a community based service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of the first day of the inspection. We gave notice of subsequent dates of the inspection to ensure the people we needed to speak with would be available.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports, action plans and notifications. Notifications are information about specific important

events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we gathered information from:

- 23 people who used the service. Two relatives or friends of people who used the service
- One health care professional who had regular contact with the service
- Eleven people's care records
- Records of accidents, incidents and complaints
- Audits and quality assurance reports
- The manager for the community based service and three assistant managers
- The provider's nominated individual and provider's senior representative
- Five office based staff within the community service
- Seven members of residential care staff and five outreach community care staff
- Two housekeepers, an administrator, activities staff, provider employed occupational therapist and a chef

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations have not been met.

Using medicines safely:

- Within the residential part of the service medicines were not always managed safely.
- When people were admitted to the service senior staff transcribed information from the hospital or person's GP onto Medicines Administration Records (MARs), which subsequent staff used when administering and recording the administration of medicines. For oral medicines a second member of staff checked these were correct and counter signed them to confirm this. However, for prescribed topical creams, inhalers, angina oral sprays and eye drops which were kept in people's bedrooms, a second member of staff had not countersigned the transcribed administration record. This meant errors would not be identified and people may not receive these medicines correctly.
- MARs for tablet medicines were fully completed. However, within the MARs records for people who kept medicines in their own room, we found numerous gaps where it was not recorded if people had received their medicines or not. These gaps had not been followed up by subsequent care staff, noted by senior staff or identified during medicines audits.
- We undertook a stock count of some tablets. We found that the number of tablets remaining did not tally with the records held for the number of tablets received or administered. In some cases, we found additional tablets remained, indicating that people had not received these as prescribed. For other people, fewer tablets remained and staff could not account for these discrepancies.
- Some people were prescribed the same medicine up to four times per day. These needed to be given at least four hours apart to avoid harmful effects however, there was no process to record the administration time. This meant people were at risk of being given their medicines without the required gap between administration times.
- Staff had not recorded the date containers of prescribed topical creams had been opened. This meant there was a risk these would be used beyond their 'safe to use' date as per manufactures guidelines.
- Medicines were stored securely but systems to ensure they were stored at safe temperatures were not being followed. Suitable thermometers were in place to record the maximum and minimum temperature of the storage room and fridge. However, maximum and minimum temperature checks were not being recorded meaning there was a risk medicines may be damaged by high or low temperatures and no action would be taken. Records of one off daily temperatures of the fridge, included some which exceeded the safe storage limits. However, there was no evidence of any subsequent action by staff to seek advice if medicines remained safe for continued use.
- One person had been without a diuretic tablet for six days the week prior to our inspection as no stocks were available. Although this was requested on the day supplies 'ran out', there was no evidence that the lack of a prescription and medicine was followed up for five days. The person was placed at risk of deterioration in their health due to the non-availability of this essential medicine.
- Across both the residential and community service not all staff who administered medicines had

completed medicines training and staff had not received formal annual competency assessments as per best practice guidelines.

The failures to ensure the proper and safe management of medicines, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they received their medicines as prescribed and that they could get ad hoc pain relief such as for a headache if required. We observed staff administering medicines in an appropriate manner.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong:
● Not all risks to people receiving a residential service were managed safely.
● Care files contained risk assessments however, not all risks were covered by these. For example, during handover staff were told a person was at high risk of choking. However, the person's care plan did not contain any information about their risk of choking or swallowing difficulties or how this risk should be mitigated. This meant we could not be assured that the risks to this person were being managed safely.
● Other people were at risk of falls. Falls risk assessments had been completed however these had not been updated following falls and not all possible action was being taken to reduce the risk of further falls. We identified people whose risk assessments, daily records and accident reports stated they had 'forgotten' or 'failed' to use the call bell to request support before mobilising and had subsequently fallen. Staff told us they had one item of movement alert equipment which was used for one person, although this was not detailed in their care file as part of their falls risk management plan. Staff confirmed this equipment would also be beneficial for other people but was not available for use with them. For other people at risk, equipment to alert staff these people were mobilising independently, was not available for use. Staff and managers confirmed that for several months, since the new call bell system had been introduced, previously used movement alert equipment could no longer be used as it was incompatible with the new system. Therefore, the risk of people falling was not being managed safely and people remained at risk.
● People's risk of dehydration was not always managed safely. We saw staff had been recording fluid intake for some people. The recording charts detailed the amount the person should receive each day however, daily amounts had not been totalled. When we added up each day's intake we found this was frequently much less than the desired amount. There was no evidence of any action being taken in respect of the reduced fluid intake. This meant that systems were not in place to effectively monitor people's fluid intake, which put people at risk of dehydration and associated medical complications.
● There was a system to record accidents and incidents. When these had occurred, appropriate action had been taken where necessary. For example, medical advice was sought and followed. The provider's policy required all accidents and incidents to be formally recorded and sent to a specific internal department for review. However, as detailed above individual risk assessments were not consistently reviewed and there was no process to consider any patterns or trends of accidents within the service.

The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Environmental risk assessments had been completed. However, we found that two first floor windows did not have restrictors in place meaning they could be opened fully. This was identified to the person in charge at the time of the inspection who arranged for these to be promptly replaced.
● Each person had a personal emergency evacuation plan (PEEP) and staff knew what action to take in the event of a fire. Fire detection systems were checked weekly. However, we were unable to confirm that other essential checks such as monthly checks of emergency lighting and exits were being completed as per the

provider's schedule within the fire folder.
● Lifting equipment was checked and maintained according to a schedule. In addition, gas and electrical appliances were checked and serviced regularly.
● For the outreach community service, individual and home environmental risk assessments had been completed by the community management team to promote the safety of both people and care staff. These considered the immediate living environment of the person, including pets, the condition of their property and security.
● Business continuity plans were in place to ensure that people's needs were prioritised in terms of risk during crisis situations.

Preventing and controlling infection:
● Not all infection control risks were managed safely.
● Not all residential based care and ancillary staff had completed infection control training. This included housekeeping staff. Additionally, not all staff, including kitchen staff, had completed food hygiene training. The failure to ensure staff had completed essential training for their role placed staff and people at risk of infections.
● When we visited the laundry room we noted three water soluble red bags had been left on the laundry floor near to clean items. These can be used for soiled laundry and placed directly into washing machines to reduce risks to staff handling laundry. One bag was split meaning the soiled items inside were not contained, placing staff and clean laundry items at risk of contamination. Staff said this had also often occurred in the past. There was no suitable container for red bags to be placed in pending them being washed. Action was promptly taken to address this issue.
● There was no separate hand washing sink for staff to use before leaving the laundry room. Staff confirmed that on occasions the one sink in the laundry room, was used to soak items in and therefore was not available for them to wash their hands before leaving the laundry room.
● The provider's standards of dress and appearance as detailed in the community staff handbook were not always enforced. This stated that fingernails should be free from varnish. The failure to enforce this policy placed people at risk of infection and meant best practise guidance for infection control was not being followed.
● The local environmental health team had awarded the home four stars for food hygiene.
● A comprehensive infection control audit had been completed in August 2018 and this stated that a further audit would be completed in January 2019. We were unable to confirm that this had been completed and an annual infection control statement was also not available.
● The residential service was clean and housekeeping staff had completed regular cleaning in accordance with set schedules. All staff, residential and community had access to personal protective equipment, including disposable gloves and aprons, which we saw they used whenever needed. Secure facilities were available for the safe storage of waste pending its removal from the service.

Systems and processes to safeguard people from the risk of abuse:
● Not all staff had received safeguarding training and some staff were unsure as to who, outside the provider management team, they could contact if the organisation failed to take action should they report a safeguarding concern. This meant safeguarding concerns may not be reported appropriately and people may not be safe.
● Duty managers and the outreach community service manager were clear about their safeguarding responsibilities and actions they would take if they had safeguarding concerns.
● People said they felt safe when receiving both a residential or community based service. A visitor said "She (relative) is very safe." Whilst another person said, "I am watched over and feel very safe."

Staffing and recruitment:

● Each shift was led by an assistant manager who had additional responsibilities for various management tasks such as training or overseeing medicines. They were also responsible for undertaking formal supervisions for a named group of care staff. To enable them to do this they were allocated specific non-contact shifts each week. However, due to a shortage of assistant managers we saw from rosters that this had not been occurring, meaning they had been unable to complete their additional responsibilities.

● There were sufficient numbers of care and ancillary staff available to keep people safe. The manager for the outreach community based service, was clear they would only accept new referrals for people if they had sufficient staff to meet their needs. Within the residential service we saw agency staff were used when needed to ensure care staff numbers were maintained.

● All care staff told us two staff were always available when specific equipment to assist people to move safely was required. This meant equipment such as hoists could be used safely. Care staff said they felt they had time to meet people's needs and did not feel rushed. They felt they had time to support people to undertake tasks themselves even though this may take longer.

● People receiving a community based service said they had the same 'group' of staff who mostly came on time and stayed for the correct amount of time. People receiving a residential based service also felt staff had the time to meet their needs and did not feel rushed.

● Recruitment procedures were robust to help ensure only suitable staff were employed, although a specific statement of an applicant's health was not obtained.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience:

- Staff had not all received training to give them the necessary skills and knowledge to safely meet people's needs.
- The residential service was in the process of compiling a matrix to show which staff had received specific training. This involved an administrator reviewing each staff members records and transcribing training information onto the matrix. When we spoke with staff they confirmed that they had not completed all necessary training. We checked records which confirmed that essential training for the roles they were employed to undertake had not been completed. For example, housekeeping staff had not completed infection control training. The action plan for the community service stated that there was a need to 'check records and ensure up to date' for medicines, infection control, emergency aid, safeguarding and food hygiene training. This demonstrated that there was no system in place to easily identify what training staff had completed or when this may be due for refresher/update training.
- One assistant manager was in the process of booking training for staff. They told us they were unable to book a new member of the kitchen staff onto food hygiene training until November 2019, meaning the staff member would be working in the kitchen for six months before this essential safety training was undertaken. We were told there were difficulties gaining places on other training, which was why not all staff had completed all necessary training.
- The failure to ensure all staff had received all necessary training to safely complete their jobs placed people at risk.
- There was no formal induction process or checklist for agency staff. We spoke with two agency staff, one of whom told us they had not previously worked at the service. One agency staff member had been provided with essential information such as about fire procedures and exits by the care staff member they were working with. However, this was not part of a formal process and had not been documented.
- The provider's policy for supervision stated all staff should receive formal supervision every six weeks. Records viewed for residential staff showed that this had not been occurring and some staff had received one supervision in the year prior to the inspection.

The failure to ensure that all staff have completed all necessary training to safely undertake their roles and received regular supervision was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider made immediate arrangements to ensure additional training was undertaken by staff which would be completed throughout April 2019.
- New staff confirmed they undertook shadow shifts as part of their induction and we saw outreach

community staff were given units of the care certificate to complete as part of their induction.
● Longer term outreach community staff also told us about update training they had completed. One staff member employed by the service was trained to deliver moving and handling training to others and this training had been provided for staff.
● Outreach community staff were receiving regular supervision including unannounced monitoring of their practice (spot checks). Most staff had received an annual appraisal.

Supporting people to eat and drink enough to maintain a balanced diet:
● People's dietary needs were assessed and met consistently. People were all positive about the meals they received and confirmed they were offered a choice.
● People receiving a residential service were offered a choice of food and drink, including regular snacks. One person said, "The food is brilliant." Whilst another person receiving a residential service said there were "good regular meals". Another person who was receiving a community based service, confirmed staff would ask them what they wanted before making any meals for them. People receiving a community based service also said care staff remembered to leave drinks and snacks, where required.
● We saw, where needed, people received appropriate support to eat and were encouraged to drink often. Where there were concerns about the amount people were eating or drinking specific records were kept, although as previously described it was not clear how these were monitored.

Supporting people to live healthier lives, access healthcare services and support:
● People were happy with care staff who they told us they supported them to access healthcare services. One person told us, "They (staff) certainly know their stuff."
● Care plans included information about people's general health, current concerns, social information, abilities and level of assistance required. This allowed person centred care to be provided.
● However, in one person's care file we found records showing that two urine samples had been sent for testing. There were no dates recorded for these samples being sought or reasons why staff had felt this necessary. There was also no record of any outcome of the samples.
● Staff were able to tell us about individual people and the care, including health needs, they required. Catering staff were aware of people who required a particular diet to meet medical needs and told us this information was always provided for them.
● Staff worked well with external professionals to ensure people were supported to access health and social care services when required. The service had access to a 'telehealth' system which meant they could send information about people's physical observations such as blood pressure directly to the local GP for review.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● Prior to admission to the residential or outreach community service, an assessment of people's individual needs was completed. This was done by staff specifically employed for this role and based at the local hospital, or by senior staff based at the service. Information from these assessments was then forwarded to the assistant managers of each part of the service for consideration. The duty managers told us they reviewed the assessments and could clarify information if required. They were then able to decide if the service could to meet their needs. A request was made to the person's GP for medical information and copies of this and hospital discharge documents were kept within care files. This would help ensure all needs were known and therefore could be met following commencement of a service.
● The assessment included people's physical, social and cultural needs. People and relatives if appropriate, were involved in the assessment process.
● The focus of the service was to promote people's independence and to provide a re-enablement service. Staff were clear that they would work to achieve these goals with the person and records viewed confirmed this. Care plans identified people's needs and the choices they had made about the care and support they

received. People were happy with the care they received. One person receiving a residential service said "They (staff) look after you really well."
● Outreach community based care staff told us that when they identified a change in people's needs, they would contact the office for a reassessment and review of the person's care plan. They said that if they felt more time was needed to complete a care visit the management team took prompt action to address this.

Staff working with other agencies to provide consistent, effective, timely care:
● The service was closely linked with local NHS hospital and community services with a view to preventing unnecessary hospital admissions and ensuring people could be discharged from hospital in a prompt manner. Some staff responsible for assessing people's needs prior to receiving a service, were based at the local hospital.
● Should a person need to be admitted to hospital, staff provided written information about the person to the medical team, to help ensure the person's needs were known and understood.
● Community outreach staff worked with social services staff to ensure appropriate information was provided if the person required ongoing community support, which would be provided by another Domiciliary Care Service.
● A community health professional told us they were contacted appropriately by the service should people have a medical need whilst in the residential service.

Ensuring consent to care and treatment in line with law and guidance:
The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● We checked whether the service was working within the principles of the MCA and found that they were.
● At the time of the inspection we were informed that everyone using the service had the ability to consent to the care that was provided for them. Staff were able to describe how they would support some people to make choices, such as showing them options and were clear that people had the right to refused planned care at any time. Staff also understood the actions they should take should a person be unable to give informed consent.
● Residential service care files contained a 'declaration of inclusion' which a senior staff member said was evidence that people had consented to their plans of care. However, this did not specifically state that people were in agreement with, or were consenting to their planned care. Community care files had been signed by the person to show they had been involved in discussions as to how their care and re-enablement needs would be met.
● People and relatives told us they were always asked before care was provided. For example, one person said, "We have a general conversation and they encourage me."

Adapting service, design, decoration to meet people's needs:
● The home was suitable to meet the needs of older people with reduced mobility. One floor of the home had recently undergone a comprehensive refurbishment programme. This floor of the home now provided large ensuite bedrooms and suitable accessible bathrooms. The provider had plans to refurbish the rest of the home over the coming year. A passenger lift was provided to enable people to access all areas of the home.
● Bedrooms were all for individual occupancy and suitably equipped to meet the needs of their occupant.

As part of the refurbishment, two bedrooms had been specifically designed to meet the needs of people with bariatric needs.

● There was access to outside spaces and within the home there were a range of communal areas suitable for the number and needs of people who accessed the service.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
● People were unanimous when asked if the carers were caring. They all told us they were treated with kindness and consideration. One person said, "Yes without doubt. That's how they're trained. I look forward to seeing them in the morning." Another person said "Caring yes. If I didn't feel they were caring I would say something." Whilst a third said "I am really satisfied and happy with the service. They have become friends and it breaks the day up so I have someone to talk to. Even the dog enjoys them coming."
● Within the residential based service, we observed people were treated with kindness and compassion by staff. Staff spoke respectfully to people and supported them in a patient, good-humoured way. When a person had a fall and was waiting for paramedics to attend, staff remained with the person continuously and provided reassurance and support.
● People's protected characteristics under the Equalities Act 2010 were explored as part of their needs assessments before they moved to the home. Staff explained how they met people's individual needs.
● People's diverse needs were detailed in their care plans and people confirmed they were met in practice. This included people's needs in relation to their culture, religion, diet and gender preferences for staff support. Some staff had received equality and diversity training.
● Staff spoke fondly about the people they supported and said they "loved their job" and it was "rewarding" to care for people. Comments from staff included: "When you see people being able to do things they couldn't and you know you have been part of that, it's such a good feeling."

Supporting people to express their views and be involved in making decisions about their care:
● Most people were aware of their care plans and confirmed they had been involved in discussions about their care and how this would be provided. For some people this had occurred whilst they remained in hospital by staff based at the hospital, whose role was to complete these assessments. On a day to day basis people were also included in decisions about how their care was provided. One relative told us, "They always talk through with him what he wants and how he wants it to be done."
● People receiving a community based service confirmed they were regularly contacted by senior staff and reviews of their care were undertaken. One person said "They [senior staff] come and review my care every two weeks." People receiving a residential based service also confirmed discussions about their care on an ongoing basis. One person said, "Together we come out with a plan."
● Most people remembered being given a choice of male or female care staff. This information was included within care records viewed and part of the pre-service assessment process. When asked one person said, "Yes early on. I did say I didn't mind but I would prefer women to wash me. I've not had a male carer."
● Staff showed a good awareness of people's individual needs, preferences and interests. Care files included some information about people's life histories and their preferences. This meant staff could use this

information when talking with people.

Respecting and promoting people's privacy, dignity and independence:
● People confirmed they were encouraged to be as independent as possible. One person told us, "There is no pressure to do things. We have a general conversation and they encourage me, and I take it on board." A relative told us "They encourage him to do what he can by himself."
● The service's aim was to re-enable people to become more independent. Staff were clear that this was their primary role when supporting people. Community based staff told us they could request additional time if this was required to enable people to undertake more tasks themselves. Residential based staff told us they had sufficient time to enable people to be as independent as possible.
● Care staff knew the level of support each person needed and what aspects of their care they could do themselves. They were aware that people's independence was paramount and described how they assisted people to maintain this whilst also providing care safely.
● We saw staff encouraging a person to walk within the residential part of the service, the person was not rushed and staff continuously told the person how well they were doing.
● People told us they were treated with dignity and respect. One person receiving a residential based service told us, "They [staff] always remember to close the doors and curtains."
● Staff explained how they respected people's privacy and dignity, particularly when supporting them with personal care by, for example, ensuring doors were closed and people were covered up.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People received individualised care which met their needs.
● People confirmed that care staff would do what was required and asked of them. A person receiving an outreach community service said, "The care is very good. They (care staff) look after me well and they make my bed for me."
● Care plans provided information about people's individual needs and how they wished to receive care and support. These identified key areas of needs, such as personal care, daily living activities, personal hygiene, dressing, meal preparation and health issues. Care plans reflected people's individual needs and were not task focussed. Care plans were reviewed at regular intervals or when a person's needs changed. However, we identified that the residential service care plans did not always include all relevant information about the person and also contained some conflicting information. For example, one person's care file stated they did not have a fluid chart. The care plan had been reviewed at the beginning of February and March 2019 and had not been amended to reflect that a fluid chart had been commenced between these dates.
● The community service manager provided information about when staff had responded to meet people's individual needs. This was confirmed by people. For example, one person told us "One of the care staff realised I had a chest infection and arranged for the doctor to come out."
● Within the residential service people were provided with opportunities to participate in a range of activities providing mental and physical stimulation.
● The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We spoke with staff about how they ensured information was accessible for all people using the service. One care plan detailed a person's communications needs and how an A-Z board had been introduced to support communication. We saw that the lunch time menu choices were written on a board which may have been difficult for some people to read. We were told that there were laminated picture cards of meal choices to assist people if needed when making choices about meals. However, staff could not find the picture cards during the inspection.

Improving care quality in response to complaints or concerns:
● People told us they would speak to a member of staff or the manager if they had a concern or complaint. One person told us, "If I had a complaint I would raise it."
● The provider had a complaints policy. Information about how to complain was available for people via service user information. This was available in all bedrooms within the residential service and within folders provided for those receiving an outreach community service. One formal complaint had been received and we saw this was appropriately investigated and a written response was provided.
● When people ceased receiving a service, they were provided with a survey requesting information about

their views of the care they had received. This would also provide an opportunity for people to make any concerns or complaints known to the service.

End of life care and support:

● No-one was receiving end of life care at the time of this inspection. Staff spoke positively about their desire to provide people with high quality care at the end of their lives, to help ensure they experienced a comfortable, dignified and pain free death. Senior staff were clear that if they were providing end of life care, appropriate support and guidance would be sought from suitable health professionals and staff would receive additional support.

● Some staff had received specific end of life care training. One staff member told us they were due to complete end of life care training in the near future. The service had links with the local hospice and staff were aware of how to access additional support should this be required.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care:

- The failure of the provider's quality assurance systems had placed people at risk of not receiving a safe effective service. Concerns we found during the inspection; included the arrangements for managing medicines safely, the management of infection control risks, failure to take all necessary action to manage individual risks, failure to review fluid recording records to ensure people were receiving adequate hydration and failure to ensure staff had received all essential training for them to safely undertake the roles they were employed for.
- There was a quality assurance process in place consisting of a range of audits completed by senior staff, the registered manager, nominated individual visits to the service. However, these had not been effective.
- We identified some examples of continuous improvement, which was monitored using a rolling 'improvement action plan'. This had been developed for both the residential and community based re-enablement services. We saw actions detailed in the plans were being completed for example, action was being taken to update the training matrix to identify all outstanding training required which could then be booked.
- There was a management structure in place, consisting of the registered manager, manager for the outreach community service and senior staff responsible for the day to day management of the service. Each had clear roles and responsibilities.
- Staff were organised and carried out their duties in a calm, professional manner. They communicated well between themselves to help ensure people's needs were met, including during handover meetings at the start of each shift.
- Comments from staff included: "I love it here, we all get on well", "I can always get support if I need it" and "we all work well as a team".

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

- People told us the service was run well and said they would recommend it to others. One person said, "It's absolutely a brilliant service. Everyone is very nice, and I can't say any more." A relative said "I would complement the whole service. The care has been incredible."
- A senior staff member for the provider and the nominated individual said they wanted the service to be the best it could be. They had a clear vision that the service was an integral part of the local health and social care strategy to enable people to receive the best possible care close to home whilst, "promoting, improving and protecting people's wellbeing." From our observations and discussions with staff it was clear that staff understood and shared this vision.

● A senior staff member for the provider, the nominated individual and community service manager, demonstrated an open and transparent approach to their roles and acted promptly to all feedback provided during this inspection. Where we identified areas for improvement on the first day of the inspection, immediate plans were put into place to address these areas. For example, we were provided with additional information showing how concerns such as staff training were being rectified. The response in respect of this was comprehensive and detailed.
● The provider understood the requirements of their registration. They had notified CQC of all significant events and had displayed the previous CQC rating prominently in the entrance hall of the residential service. There was a duty of candour policy in place to help ensure staff acted in an open way if people came to harm. Senior staff were clear as to when and how this should be used.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● The service consulted people in a range of ways. For many people the service provided was for short term, time limited re-enablement. When this was completed all people were offered the opportunity to complete a questionnaire survey about the care they had received. The results for these were collated annually and we were provided with the report for 2018. This showed people were generally very positive about the service they had received. Senior staff also undertook regular reviews with community service users. These showed people were happy with the support they were receiving.
● Staff told us they felt engaged in the way the service was run and enjoyed high levels of morale. They gave examples of where they had made suggestions for improvement, which had been adopted.
● The service experienced low levels of staff turnover. Staff said they were happy working for the provider and felt able to raise issues or concerns with the management team.
● Staff spoke positively about the management team, describing them as "approachable" and "supportive." Comments from staff included: "They are very approachable" and "You can go to them with anything, they listen to you".

Working in partnership with others:
● The service had very close links with local health and social care services and worked in collaboration with all relevant agencies, including health and social care professionals.
● Some staff were based within the local hospital to ensure prompt pre-service assessments were completed. This facilitated smooth and effective hospital discharges and also involved community professionals to prevent hospital admissions, wherever possible.
● Should people need to move to a longer term residential or community based service senior staff were clear about the need to share information to ensure a smooth transfer of care to new providers. This all helped ensure people received the right care and support when they needed it.

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 Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe management of medicines, and risks to individual people. Regulation 12 (1)(2)(a)(b)(c)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure that all staff have completed all necessary training to safely undertake their roles and received regular supervision was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.