Lonsdale Midlands Limited

18 Bushwood Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 March 2017. This was an unannounced inspection.

At the time of our last inspection in March 2016, the provider was found to be requiring improvement in two out of the five areas that we looked at, namely whether the service was safe and well-led. This was because the staff had not always recognised when an accident or incident that had occurred at the home should have been referred as a safeguarding concern to the local authority for a thorough investigation by an independent body. The registered manager had also failed to notify us of such events, as required by law. During this inspection, we found that improvements had been made in these areas. However, we identified additional shortfalls and further improvements were required.

18 Bushwood Road provides accommodation and personal care for up to six people with physical and learning disabilities who require support to live in the community. At the time of our inspection, there were six people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by enough members of staff in order to keep them safe. However, the provider did not always ensure that there were enough staff available to support people to live enriched and fulfilling lives. People did not always have the opportunity to engage in activities that they enjoyed outside of the home because there was not always enough staff available to support them to do this.

People were protected from the risk of abuse and avoidable harm because staff received training and understood the different types of abuse and knew what actions were needed to keep people safe. The provider had also ensured effective systems were in place to report and investigate any concerns raised, which included working collaboratively with external agencies and reporting these to us, as required by law.

Staff had the knowledge and skills they required to care for people safely and effectively. This included the safe management of medicines so that people received their medicines as prescribed.

People were supported by staff that were kind, caring and respectful. People were encouraged to be as independent as possible and were treated with dignity and respect. People had access to enough food and drink in accordance with their dietary requirements. However, meal times were not always person-centred and not all of the people living at the home were given flexible food choices that reflected their personal preferences.

People and/or their representatives were involved in the planning and review of their care, as far as

reasonably possible and were aware of the complaints policy and procedure. The provider sought feedback from people who used the service and/or their representatives, as well as from visiting professionals in order to drive improvements.

Whilst the provider had some additional management systems in place to assess and monitor the quality of the service provided to people, these were not always effective in identifying the shortfalls identified during the inspection. The registered manager was open and honest in their communication with us and recognised that further improvements were required in this area.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

People were supported by enough members of staff in order to keep them safe.

People were supported by staff that had been recruited safely.

People received their prescribed medicines as required.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration. However, meal times were not always person-centred and people were not always offered flexible meal time choices.

People received care and support with their consent, where possible and people's rights were protected because key processes had been followed most of the time, to ensure people were not unlawfully restricted. However, staff were not always aware of the implications that deprivation of liberty safeguards had on the people that they cared for.

People received care from staff who had received adequate training in most areas and had the knowledge and skills they required to do their job effectively.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and caring.

People received the care they wanted based on their personal preferences and dislikes because staff took the time to get to know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were supported and encouraged to engage in activities that were meaningful to them and to maintain positive relationships with people that were important to them. However, the provider had not always ensured that there were enough staff available to support people to engage in activities outside of the home and live enriched and fulfilling lives.

People and their relatives were involved in the planning and review of their care, as far as reasonably possible because staff communicated with them in ways they could understand.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team had systems in place to assess and monitor the quality of the service. However these had not always been implemented effectively and had failed to identify some of the shortfalls we found during our inspection.

Staff felt supported and appreciated in their work and reported the management team to be approachable.

The provider had met the requirements of their registration because they had notified us of information that they are lawfully obliged to share.

18 Bushwood Road

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 took place on 29 March 2017. The inspection was conducted by one inspector and an inspection manager.

As part of the inspection we looked at the information that we held about the service prior to visiting the location. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also looked at information that the provider had sent to us in their Provider Information Return (PIR). A PIR is a pre-inspection questionnaire that we send to providers to help us to plan our inspection. It asks providers to give us some key information about the service, what the service does well and any improvements they plan to make. We contacted the local authority and commissioning services to request their views about the service provided to people at the home, as well as consulted Health watch. Health watch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection visit, we spent time with the six people who lived at the home. We also spoke with two relatives and an advocate. An advocate is a person who seeks to ensure that people are supported and able to have their voice heard on issues that are important to them, defend and safeguard their rights and have their views and wishes genuinely considered when decisions are being made about their lives. We spoke with four members of staff including the registered manager and three support workers. Some of the people living at the home had complex care needs and were unable to tell us about the service they received. Therefore we used a tool called the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of two people, to see how their care was planned and looked at the medicine administration processes. We looked at training records for staff and at one staff file to look at recruitment

and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, medication administration audits, accidents and incident records and compliments and complaints.

Good

Is the service safe?

Our findings

At our last inspection we found that staff had not always recognised when incidents that had occurred within the home, should have been referred to the local authority's safeguarding team for an independent investigation. Such incidents included medicine errors and times when staff had noticed bruises to a person's body. Whilst these had been reported to the management team and investigated internally, the appropriate procedures had not been followed to ensure that people were kept safe from the risk of abuse and avoidable harm. During this inspection, we found that improvements had been made. Information that we hold about the service showed that since our last inspection, such incidences had been reported to the local safeguarding team and the provider had also notified us, as required by law. When safeguarding concerns had been raised, these had been fully investigated by the local authority and had not been upheld. Outcomes of the investigations showed that the provider had taken all of the appropriate action to protect people from the risk of abuse and avoidable harm. Records we looked at showed that the registered manager had considered the root cause of each incident and identified ways to prevent the incidents re-occurring. For example, we saw how one person had repeatedly hurt themselves on their bed frame due to involuntary movements as part of their physical health condition. We found that the registered manager had referred them to the relevant health professionals for a re-assessment of their needs and specialist equipment. As a result, the person now had a new bed and wheelchair that protected them against accidental injury.

Everyone we spoke with told us that they thought people were well looked after and were safe living at the home. One relative told us, "[person] is very well looked after; I am confident she is safe". Another relative said, "I am more content knowing [person] is there, I can see she is well looked after and safe". Throughout the inspection we saw that people looked relaxed and comfortable in the presence of staff and that the environment was well maintained and secure in order to protect the safety of people living at the home.

All of the staff we spoke with knew what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "I am confident that people are safe here; they are well cared for, but if I had any concerns at all, such as safeguarding concerns, I would report it straight away, but this is a good home". We saw that staff had received safeguarding training and they were knowledgeable in recognising signs of potential abuse; staff knew how to escalate concerns about people's safety to the provider and other external agencies as directed by the safeguarding policy.

We saw that risks to people had been identified and records we looked at showed that people had risk assessments and management in place to help to keep them safe. Staff we spoke with knew how to protect people from risks associated with their health conditions and were aware of what action they needed to take in an emergency, such as choking. One member of staff told us, "We have first aid training. If a person was choking I would call for assistance and if it's considered an emergency, we'd call 999. I would look to see if there was an obstruction [to their airway] and apply five back slaps to dislodge it or an abdominal thrust; I'd keep doing this until the paramedics arrived". Another member of staff said, "People all have their different physical needs; some people have seizures which we have to manage to keep them safe. For example [person's name] is known for having seizures, we monitor them, offer reassurance, we have

medicines we have to administer if we need to and we can usually deal with it here, whilst [person] has only recently started having seizures, so for them, we call the ambulance straight away because we don't have any guidance for her yet". We observed staff members attending to a person who was experiencing a seizure. Staff remained calm, offered gentle reassurance and adapted the activity that the person was engaged in at the time of the seizure in order to keep them safe. We checked the risk assessment and care plan for this person and found that the staff had responded appropriately and had followed the guidance provided to them by the person's epilepsy specialist.

Everyone we spoke with told us that they thought there were always enough staff available to keep people safe. One relative told us, "There seems to be enough staff". Another relative said, "There is always someone about". We saw staff that were available to meet people's physical health and care needs throughout the day in order to keep them safe.

We saw the provider had a recruitment policy in place and staff had been appropriately recruited via a formal interview, references, and a Disclosure and Barring check (DBS). Staff we spoke with told us they had completed a range of pre-employment checks before working unsupervised. We saw that staff were required to satisfy a number of competencies during their probation period of six months, before they were permanently employed by the organisation. One member of staff we spoke with told us, "It [recruitment] was very thorough and [registered manager's name] has been very supportive".

We were told that all of the people living at the home required support to take their medicine and that only staff that had received training administered medicines in the home. A relative we spoke with said, "They [staff] make sure she [person] has all of her medicines and I know she suffers with pain, which they give her paracetamol for, which is good". We observed one member of staff administering medicine and found that where people lacked the capacity to consent to taking their medicines, these were given within their best interests, as documented within their care plans.

We saw that medicines were stored safely and that protocols were in place to support staff with administering these effectively, including those that were prescribed on a 'as and when' (PRN) basis. Most of these protocols were sufficiently detailed and personalised to ensure that staff knew what signs and symptoms a person may present with to indicate they required the medicine and included instructions on what action staff should take in order to administer the medicine safely. However, we saw that the PRN protocol for pain relief such as paracetamol was not always specific to people's individual needs and this was fed back to the registered manager at the time of our inspection. The manager assured us that this would be addressed as a matter of priority. Medicines' records were found to be accurate and detailed and processes were also in place to identify missed medication early. The provider also reported to have a good rapport with the local pharmacy to ensure that people received their medicine when they needed it.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with including the registered manager had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA 2005 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. Staff we spoke with confirmed that they had received training on the Mental Capacity Act (2005) and were able to give examples of how they worked within these legal parameters and protected people's rights and the need for consent. One member of staff told us, "We offer choices to everyone despite whether or not they have capacity to make decisions, but some people aren't able to tell us their choices or preferences about things, so we make decisions within their best interests". Another member of staff told us that they got to know people well enough to know how to communicate with people to allow them to make choices. They said, "One person will make a choice by pointing with their eyes, or will smile for yes and frown for no, other people aren't able to tell you and it can be trial and error; if they don't eat something you offer them something else until you get it right".

Care plans we looked at showed that staff were encouraged to continue offering day to day choices to people despite their mental capacity to consent. We also saw that people's relatives or advocates were involved in making decisions regarding their care or significant life events within their best interests. An advocate is a person who seeks to ensure that people are supported and able to have their voice heard on issues that are important to them, defend and safeguard their rights and have their views and wishes genuinely considered when decisions are being made about their lives. We saw that the proper processes had been followed in making some best interests decisions on behalf of people who lacked the capacity to consent to the care and treatment they received.

However, we found that where best interest decisions had been made about people's medicines, the proper processes had not always been followed or recorded as such. For example, a care plan we looked at said that a person lacked the capacity to make decisions about their medicines and that medicines were to be given to this person within their best interests. We saw that this person was supported to take their medicines with their food. We were told that this was because they would not take it any other way and that they needed the medicines in order to keep them well. We did not see how this decision had been made, who had been consulted about this decision and whether this method of administration posed any risks to the efficacy of the medicines or whether any alternative options had been considered. We fed this back to the registered manager at the time of our inspection. We saw that they had responded to our feedback immediately. They had started to make arrangements to consult people's relatives/advocates and GP's in order to follow the appropriate processes. This was to ensure that medicines that were being administered within people's best interests including those being administered covertly were done so lawfully.

Deprivation of Liberty Safeguards (DoLS) requires providers to identify people in their care who may lack the mental capacity to consent to care and treatment. They are also required to submit an application to a 'supervisory body' for the authority to deprive a person of their liberty within their best interests in order to

keep them safe. The registered manager was able to articulate their understanding of DoLS and was aware of their responsibilities. We saw that where DoLS authorisations had been granted or applications had been submitted, copies of the relevant forms were in place. The registered manager also had a system in place to enable them to monitor when an authorisation was due to expire and the need to re-apply within good time (as required), to ensure that care was being provided to people lawfully. However, despite having training, some of the staff we spoke with were not always aware of who had DoLS authorisations in place and what implications this had on how they cared for people on a day to day basis. We fed this back to the registered manager at the time of our inspection and they advised that a refresher training session would be facilitated with all members of staff.

Staff we spoke with told us that they prepared all the meals on site and they offered people the food and drinks that they enjoyed. One member of staff told us, "We have a four week menu rota which offers some variety; but people can choose what they want to eat if they don't want what is on the menu". However, on the day of our inspection, we found that not all of the people living at the home were able to tell staff what they wanted to eat and were not always given a choice. For example, we saw that the menu options for lunch on the day of our inspection were either Irish stew or rice pudding. The member of staff that was preparing the lunch told us that they rarely had Irish stew in stock and so they defaulted to the next available option and everyone (apart from one person on a specialist diet) had rice pudding. We saw some variation whereby some people had golden syrup and others had jam, but otherwise, people were not given a choice about what they had to eat. A staff member also told us that they thought it was 'strange' for people to have rice pudding as a main meal as they considered this to be a dessert. They said that they had raised this with the previous manager when they first joined the service but nothing was done about it. Other members of staff we spoke with including the registered manager agreed, but we were told that this had been a menu option for many years and people appeared to enjoy it. This showed that there was little flexibility or review of the food options available to people within the home.

We also found that one person had a separate menu to the other five people living at the home and we were told initially that this was because of their individual dietary requirements. However, we found that some of the food options available on the generic menu would have been suitable for this person too, despite their specialist diet needs. We were later told that this person was very particular about what they would and would not eat and that was why they had a menu that reflected their personal preferences. A relative we spoke with said, "[Person] has their own menu, but not everything [person] likes is particularly good for them. They [staff] tell me she won't eat vegetables but I think they [staff] could try a little harder to introduce healthier foods in to her diet. I have discussed this with them and we are working together to encourage her to eat better". We saw that much of the food prepared for people was convenience foods such as tinned or frozen foods. We discussed all of these issues with the registered manager at the time of our inspection. We explained that for equity and in keeping with person-centred care, everyone should be given food that reflected their individual likes and dislikes, with greater flexibility and choices available.

We observed a meal time where all six people were supported to eat in the dining room. We saw that some people had to wait for their food because there were not always enough staff available to assist people at the same time. This meant that some people's food was left to go cold until a member of staff was available to support them. We were told that specialist bowls were available that kept food warm and staff should have been using these. The registered manager acknowledged that increased staffing levels or a staggered meal time may improve the meal time experience for people living at the home.

We saw people were supported to maintain their independence with eating and drinking as far as reasonably possible. For example, one member of staff said, "Usually [person] eats independently and doesn't need our support but her tray broke at the weekend so I am supporting her because she can't hold it

[plate] herself". We saw that this had been reported and we were told that a new tray had been ordered. We also saw another person was given an adapted cup which allowed them to control the flow of fluid to enable them to drink independently. Records we looked at also showed that people had care plans and risk assessments associated with their dietary needs. These detailed people's specific needs and risks in relation to their diet. We saw that where people were at high risk associated with their diet or fluids they were referred to the appropriate medical professionals such as Speech and Language Therapists and Dieticians. Staff we spoke with told us, "Some people have special dietary requirements; for example [person's name] has to have their food pureed because they are risk of choking and we have to support [different person's name] to maintain a healthy diet because of their diabetes". We saw evidence of this in people's care plans.

Relatives and staff we spoke with and records we looked at showed that staff had the knowledge and the skills they required to do their job safely and effectively. One relative told us, "They [staff] are all wonderful; they work together as a team and they are all brilliant at their jobs". Another relative said, "They [staff] are very good; they seem to know what they are doing". One member of staff we spoke with said, "We have to do a lot of training which is in line with the care certificate so we learn a lot when we first start and then have refreshers; [registered manager's name] will tell us when we are due to re-do any training". We saw that the provider kept a record of staff training which detailed the dates of when staff had completed various training courses. We found that staff were responsible for maintaining their own training competencies which was monitored by the registered manager. Staff were reminded in the team meetings and supervision sessions when training was due to or had expired and that the registered manager would manage staff compliance accordingly.

We were told and records showed us that the provider offered regular team ("house") meetings and supervision to staff. Staff felt supported in their jobs. One member of staff told us, "I have supervision every eight weeks. I find this supportive as I can get everything off my chest but [registered manager's name] is always there to talk to anyway whatever the problem is". Another member of staff said, "We do have team meetings and I will always raise any issues I have but not all of them [staff] do; I don't know why. I would say though that we don't always see what's been done from what we have raised, like the rice pudding issue for example, nothing was done about it". We fed this back to the registered manager at the time of our inspection and they assured us that greater attention will be given to updating and feeding back to staff on issues they have raised.

People had access to doctors and other health and social care professionals. For example, we found that some people had nutritional assessments and care plans in place that had been informed by the assessment and guidance of Speech and Language Therapists and/or dieticians. We also saw that other people were regularly reviewed by an epilepsy specialist. We found that district nurses visited the home regularly in accordance with people's health care needs and GP appointments were sought as required. A relative we spoke with told us, "They [staff] make sure she sees who [professionals] she needs to see and attends any appointments that she has; they are good at feeding back to me as well and keeping me informed". We were told by a relative about a time when their loved one had had a seizure and the staff had called emergency services. The person was taken to hospital and the relative said, "I am glad she was there [at the home] and they [staff] called an ambulance. A carer [staff] went with her to the hospital to keep her company and they rang me every hour to keep me up to date because they know I worry; it is wonderful". Records we looked at confirmed that people had health passports and had access to specialist services for their physical and learning disabilities. This meant that people were supported to maintain good health any health care concerns were followed up in a timely manner with referrals to the relevant services.

Good

Is the service caring?

Our findings

Everyone we spoke with were complimentary about the staff team. One relative told us, "They [staff] are all wonderful, very kind and caring." Another relative said, "I am a great 'people watcher' and a good judge of character, when I go there [at the home], I see them [staff] talking to people and stroking them caringly; it's really lovely to see because unfortunately, that doesn't happen everywhere. I am so much happier now she is there [at the home]". An advocate we spoke with said, "At the times of my visits I have witnessed staff interacting well with clients [people] and have a very caring nature".

We heard about how the staffs' caring approach extended to the care of visitors and relatives too. One relative said, "They [staff] look after me when I am there too, they meet me from the taxi because they know I am unsteady on my feet and make sure I have plenty of drinks; they are just wonderful". We found staff to be attentive during our visit and were continuously checking on our comfort and well-being, offering us drinks throughout the day. An advocate we spoke with confirmed that this is typical of the staff and they said, "They [staff] are always very welcoming and it [the home] has a homely feel to it".

We found that people received their care and support from staff who had taken the time to get to know them and who understood their history, preferences and needs. One relative said, "They [staff] know her very well; the slightest thing [change] and they are on to it". Another relative we spoke with told us, "They [staff] look after her very well, she couldn't be cared for any better anywhere else, they know her very well and she is contented there". An advocate we spoke with told us that they believed that the staff knew people's needs well and were able to give them all of the information they needed when they visited the home. Records we looked at confirmed that people and their relatives (where required) had been involved in the planning of their care and were supported to make decisions about most of the support they or their loved one received. We saw people had person-centred support plans which informed staff of people's needs and preferences which included their communication needs. We also saw that the staff had developed photo albums titled 'all about me' which had information about people's likes, dislikes, needs and preferences which were depicted using photographs of people engaging in activities or other representative photo's, making it accessible to the people they were about.

We observed positive interactions between staff and people who used the service and saw that people were relaxed with staff. We saw people smiling and laughing with staff and when a person showed signs of distress, they were reassured by staff contact. It was clear that there were friendly relationships between the staff and the people using the service.

Everyone we spoke with told us that people were treated with dignity and respect and we saw that people looked clean and well cared for. One relative said, "They keep on top of it [personal care] and she always looks tidy and well cared for". Another relative told us, "They [staff] are very respectful and it's dignified". Staff we spoke with told us how important it is to make sure they protect people's privacy and dignity. One member of staff said, "We close doors and keep people as covered up as possible to protect their modesty". Another member of staff said, "I think it's important to make sure people look nice and are comfortable in what they wear". Staff we spoke with and records we looked at told us that one person liked the colour pink

and liked to wear make-up. We saw that staff had supported this person to apply make-up and was wearing clothing in her favourite colour. A member of staff said, "She [person] loves anything 'girlie'; you will be able to tell straight away which room is hers! Everything is pink! Her chair, clothes, bedroom! She loves it!"

Staff we spoke with told us that they promoted equality and diversity within the home. One member of staff said, "We treat people fairly but respect them all as individuals. They [people] all have their own personalities". Another member of staff said, "We respect people's cultural needs, for example, we have people here who have to have special shampoo for their hair because they are afro-Caribbean and their key worker is also looking for an afro-Caribbean day centre". We saw that staff had taken the time to consider people's sexuality, as far as reasonably possible. For example, we saw one person was recognised to enjoy the company of men, whilst another stated that the person liked being around both men and women and did not show a preference.

Requires Improvement

Is the service responsive?

Our findings

Staff we spoke with and records we looked showed that people rarely had the opportunity to go out and engage in activities outside of the home. The staff we spoke with told us that this was because they no longer had a 'driver'. The registered manager explained to us that at the time of our last inspection, the previous manager was able to drive the mini bus. However, since the previous manager had left, the service no longer had a member of staff that was either trained or willing to take on the responsibility to drive the mini-bus. A staff member we spoke with said, "We will take people for walks locally or use taxis but we can't go anywhere too far because of the costs". We were also told that the current staffing levels did not always facilitate community outings. The registered manager said, "We need at least four or five members of staff to be able to go out with people and it's rare that we have that level of staffing now".

During our inspection we did an audit of the amount of time people spent out of the home. We looked at the activity logs for three people over a three month period and found that only two people had left the home on two occasions to go for a short walk to the neighbouring duck pond. Relatives we spoke with told us that people didn't tend to go out that often but were occupied within the home. One relative told us, "They keep her [person] occupied the best they can; they know what she likes". Another relative said, "[person's name] interests are eating and music, so that can be done in the home; she seems happy and content". However, from records we looked at and from speaking with staff, we found that some of the people living at the home had enjoyed going out previously and that this was something that they potentially missed. For example, in one person's care records, we saw that they enjoyed going out to the theatre. A member of staff we spoke with told us about how another person loved anything to do with planes and trains and they enjoyed going out to railways and airports. We saw photographs of the person visiting a railway station; they were smiling with staff and appeared to be enjoying the day out. The staff member said, "He loved it [going to the railway]! We have taken him to the airport before too and sat in the viewing area to watch the planes which he really enjoyed; we had planned to take him again a few weeks back, but this had to be cancelled because we couldn't get the transport". The registered manager acknowledged that this was an area in need of improvement.

Throughout our inspection, we saw that the staffs' time was mostly occupied with task led activities and they had little time to engage with people in activities of interest, particularly in the mornings. This was confirmed by the staff we spoke with. We found that the service was currently running on minimum staffing levels. The registered manager said, "We can manage safely on three members of staff but this is the minimum, ideally we like to have four or five members of staff available so we can do more with people, but we have had a few members of staff leave recently due to personal reasons and we are finding it difficult to recruit, mainly due to the positions [care assistant] being advertised at minimum wage". They told us that they had raised their concerns about the limited staff and transport resources with the provider at a recent manager's meeting and they were hopeful that this would be reviewed.

We saw people were given the opportunity to engage in activities that they enjoyed independent of staff interaction throughout the day such as looking through books of interest and passively listening to music. However, the registered manager acknowledged that increased staffing levels would allow the staff time to

engage with people in more meaningful and stimulating activities. The registered manager also said, "We [staff] do as much as we can to offer some stimulation. It makes you realise when you do a 12 hour shift, just how boring it could be for people. That is why I have developed the activity corner". We saw that the registered manager had dedicated a corner of the home to house activity equipment for people to get involved in, such as darts, skittles, jigsaws and a pool table. The registered manager said, "I asked those [people] that could tell me about what they thought of my ideas and they got really excited but I wanted it be a big surprise. When we did the 'big reveal', the looks on their faces were priceless and we had some lovely feedback from a relative too. Just because they [people] may not be able to do the activities themselves, they appreciate being part of a team and the fun of it". We also saw that the registered manager had arranged for someone to visit the home to facilitate exercises with people, which people appeared to enjoy. We were told that this happened on a regular basis.

We found that people were supported to maintain personal relationships and social contact with their relatives and friends. A relative we spoke with said, "They [staff] arrange for me to have a taxi to come and visit as often as I can. It's usually once a fortnight. I'd like to visit more often but I have my own physical problems, so I asked for fortnightly; they are very good at keeping me informed about anything in between". Another relative said, "I go as often as I can but I know she is safe and happy, that's the main thing". Records we looked at confirmed that people had visitors to the home and that this formed part of their activity schedule.

Relatives we spoke with told us that they were aware of their loved one having a care plan and confirmed they were involved in this process. A care plan is a written document which details people's care needs and preferences; it informs staff of how a person wants to have their care needs met and how they can support them and provide this care. One relative said, "Yes, I am been involved, they always speak to me about things and they check I am still happy with things". Another relative told us, "I am invited to meetings about [person's name] care but I can't always attend, but they will call me". We saw that advocates were also consulted to represent people during care reviews or best interests meetings. An advocate we spoke with said, "I have been involved with a client [person] at 18 Bushwood Road and as part of my role I visit them every four weeks and support any decision making processes where possible". These arrangements ensured people's individual needs were included in the care plans and care was provided within people's best interests where necessary.

People we spoke with and records showed that the provider often asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One relative said, "We can speak to the staff at any time and the manager whenever we want to and they do ask us if we are happy". We saw that the provider also requested feedback from visiting professionals. Feedback given by a District Nurse read, "Staff always maintain privacy and dignity, they are very caring and always helpful. They always bring any concerns to the attention of the District Nurses". Another praised the staff for being 'helpful and friendly'. We saw that there was a compliments and complaints procedure in place and that people were encouraged to raise any concerns with the registered manager at any time.

Everyone we spoke with told us they knew how to complain. One relative said, "I definitely would [raise a concern] if I needed to. I'd speak to the manager straight away". During our inspection, the registered manager told us that there were no outstanding complaints from people who use the service or their representatives. Information we hold about the service showed that we had not received any complaints bout the service since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last inspection we found that the registered manager was not meeting the standards required of their registration because they had not reliably ensured that information that they were legally obliged to tell us, and other external organisations, such as the local authority, including safeguarding alerts were sent. Since our last inspection, a new manager had applied for their registration with us. Information we hold about the service, relatives and staff we spoke with as well as records we looked at, confirmed that the new registered manager was meeting the legal requirements of their registration and information they are required to send to us by law, had been sent. However, we found that further improvements to the management of the service were required because shortfalls we found during the inspection had not always been identified or acted upon.

We saw that there were some systems in place to monitor the quality and safety of the service, and that most of these were used effectively, including feedback forums and surveys, staff recruitment process and quality monitoring audits. However, other areas in need of improvement had not always been identified or acted upon since our last inspection. The provider had failed to act upon concerns relating to the lack of resources that were available to enable people to engage in activities outside of the home, including staffing levels and transport facilities. We were told that historically the provider had employed a 'driver' whose time was shared amongst all of the provider's local homes, but that this person had been made redundant a couple of years ago. This redundancy had not initially impacted upon the people living at the home because the previous registered manager was able to drive the mini-bus. However, since the previous manager had left, the service no longer had a member of staff that was either trained or willing to take on the responsibility to drive the mini-bus. The provider had not made any arrangements to accommodate this lack of resource to date. The registered manager told us that they had raised their concerns with senior management at a recent manager's meeting but there was little else they could do to improve this situation without the support of the provider.

We also found that issues relating to a person not having access to their personal transport provision had not been identified by the registered manager. For example, we found that one person had their own Motability car but they could not use this because none of the staff working at the home would drive the vehicle. Instead, this person was required to pay other transport costs such as taxi fees despite already having access to their own vehicle. A member of staff we spoke with said, "It's a shame because the car is there but it is never used". We saw that regular checks on the vehicle had been carried which were overseen by the registered manager as part of the quality monitoring process. These checks included mileage checks which showed that the car had not been used for a number of months. However, we did not see any evidence that this process had provoked any indication of concern or that any discussions had been held about returning the vehicle so that the person could receive a monetary benefit instead of the vehicle, to support them in paying for any additional transportation costs. We also found that the registered manager had failed to identify and/or address the lack of person-centred care and choice at meal times, despite them reportedly being aware of some of the issues we had discussed with them during the inspection visit. Nevertheless, we found the registered manager was responsive to our feedback and took immediate action to consider ways that these issues could be prevented in the future. We were confident that they will reliably

address and improve their practice in these areas accordingly.

Everyone we spoke with was complimentary about the management team. One relative told us, "[registered manager's name] is great; I can't fault any of them". During our inspection, we saw the registered manager was visible and present and played an active role in the delivery of care and led by example. They knew people well and spoke of people and their family with compassion. They were proud of their development journey as a manager and the improvements they had made since our last inspection. They said, "I know everyone really well and I can relate to the staff because I started here as a carer and worked my way up. I am very proud of our home and the staff; we do our best for people and anything I can improve on I will". We saw that the registered manager's progression was recognised by other members of staff and gave them hope for the possibility career progression within the organisation. Staff we spoke with also told us that the registered manager was approachable, open and honest in their leadership style. One member of staff said, "She [registered manager] is very supportive we can go to her about anything. She is supporting me to develop too".

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and that there was a whistle-blowing policy in place. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal or to external agencies, such as CQC if they do not feel confident that the management structure within their organisation will deal with their concern properly. All of the staff we spoke with told us that they felt comfortable raising concerns with their registered manager but knew that they could contact external agencies, such as ourselves if they needed to. One member of staff told us, "I am confident that [registered manager's name] would deal with anything but if I was concerned I can use the whistle-blowing policy and call you [CQC]".

We asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was able to tell us their understanding of this regulation and how they reflected this within their practice. They said, "I want to ensure we are doing the best we can do for people and if there are things I can improve on I will. I am still learning and developing within the role and I come across something new every day, so I am happy for all the advice and support I can get".