Care Quality Commission

Westward Care Homes Limited

Westward Farm

Inspection report

School Lane,
Besthorpe
Attleborough
NR17 2LH
Tel: 01953 451542
Website: westwardhealthcare.co.uk

Date of inspection visit: 23 and 26 October 2015
Date of publication: 26/01/2016

Ratings

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

Overall summary

The inspection took place on 23 and 26 October 2015. It was unannounced.

The service is a care home for up to 19 people with a learning disability. People living in the home have their own flats.

There was a registered manager in post overseeing this and one other care home. 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 protected from the risks of infection as far as practicable, including infections associated with poor food hygiene practices. Proper recruitment processes were in place to contribute to promoting people's safety, with minor gaps in the way they were applied.

Summary of findings

People received support from a more consistent and stable staff team and changes were being made to shift patterns to provide more flexibility for people. Staff understood their obligations to report concerns that someone may be being harmed or abused.

Staff training in some areas was improving but the service people received was not always consistently effective. The majority of staff lacked training in the Mental Capacity Act 2005 and associated Deprivation or Liberty Safeguards. They did not demonstrate a clear understanding of how they should support people to make informed decisions and how people's rights were to be promoted. However, senior staff were better informed and had taken action to seek appropriate authority if restricting a person's freedom was the only way to keep them safe.

Staff supported people to eat and drink enough and understood the importance of this to people's well-being. They were alert to changes in people's health and how they should promote people's health and welfare. Staff also had a good understanding of each person's individual needs and preferences and how they should be supported.

Staff responded to people in a warm and respectful manner and took action promptly to offer support if people became anxious. People felt their privacy was respected but the provider's system for monitoring staff safety significantly intruded upon people's privacy in their own rooms.

Recent management restructuring provided the service with better leadership and staff morale had improved. However, systems for monitoring and improving the service were not as effective as they could be in identifying where improvements were needed.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

The consistency of staffing had improved. Recruitment processes contributed to promoting people's safety with minor gaps in the way they were applied.

Medicines were given to people in a safe way.

Infection control and food safety measures contributed to promoting people's safety.

However, the service could not show that the use of restraint was always consistent with people's rights.

Good

Is the service effective?
The service was not consistently effective.

Staff training was not always delivered in a timely way to ensure that people received support from staff who were fully competent. Staff were not all clear how they should support people in line with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

People were supported to eat and drink enough.

If people became unwell staff sought medical advice promptly to promote their health.

Requires improvement

Is the service caring?
The service was not consistently caring.

There was use of monitoring equipment, primarily to promote the safety of staff and of people with epilepsy, but which intruded upon the privacy of people using the service.

People were supported by kind and respectful staff who understood how people communicated and responded to signs of anxiety or distress promptly.

People were supported to stay in touch with their family if they wished.

Requires improvement

Is the service responsive?
The service was responsive.

Staff supported people with care that was focused on individual needs and preferences.

Complaints were listened to and acted upon.

Good

Is the service well-led?
The service was not consistently well-led.

Requires improvement

Summary of findings

The registered manager had not told us about events happening within the service that were required to be notified.

Systems for monitoring the quality of the service were not always effective in identifying where improvements were needed.

Staff morale and motivation was improving and they felt better supported by a more approachable management team.

Westward Farm

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 inspection took place on 23 and 26 of October 2015. The first day was unannounced. It was carried out by two inspectors.

Before we visited the service we reviewed the information we hold about it. This included information about specific events taking place in the service, which the provider is required to notify us about by law. We also reviewed any information we had received about complaints or concerns.

During the inspection we spoke with three people using the service, two senior support workers, a unit leader, and eleven support staff. We also spoke with the service manager overseeing the site and the registered manager. We observed the way that people were being supported.

We reviewed medication records and records relating to the care and support of four people. We also reviewed in detail the care that one person received.

In addition we looked at other records associated with monitoring the quality and safety of the service. This included recently completed surveys from three professionals providing advice and support to the service and from eight relatives of people living at Westward Farm.

Good

Is the service safe?

Our findings

Between the inspection of Westward Farm in June 2014 and this inspection, we had received a number of concerns about the safety of the service. These included concerns about the inappropriate use of physical intervention to restrain people, staffing levels, and poor attention to food hygiene and infection control. We followed up these issues during our inspection.

One new member of staff told us about their recruitment process. They said that they had completed an application form and attended an interview. They also confirmed they had been asked for details of people who could supply the provider with references in relation to their previous work and for proof of their identity. An enhanced disclosure had been completed to ensure that they were not barred from working in care.

We reviewed recruitment records for three staff. The provider's application form asked prospective staff to provide a full employment history. The registered manager acknowledged to us that one of these staff did not have a complete employment history, despite having a long history of working in care. We found that this had not been explored in the staff member's interview to obtain the information and establish the reasons they had left previous posts in care services. However, references were taken up and enhanced checks made to ensure staff were not barred from working in care.

Staff told us that there had been a lack of consistent staff to provide people with the care they needed in the past. However, they felt that this was getting better. Staff said that there had been recent improvements in the staffing structure. They told us that people were getting the one to one support they needed, or two to one, if this was appropriate. One staff member said, “This did not always happen at the weekend before and we had lots of problems, especially with some staff who did not want to work but just sat around talking.” The service manager acknowledged that this had been an issue but also confirmed that the situation had improved.

A visiting professional commented in their questionnaire that they felt the turnover of staff, particularly at management level and team leader level, remained a concern. However, the management team provided us with information showing that staff turnover had decreased recently. A relative had also noticed this and commented, “It is good to see more staff being retained.”

Staff told us how they worked in ‘core teams’ to support specific people. The service manager and deputy manager told us about further planned changes in duty rosters. They said they felt this would further improve the consistency of support people received. Staff also identified this would allow more flexibility in the way people were supported throughout the day. We concluded that there were enough staff to support people safely and that arrangements remained under review so that further improvements would be made.

Staff told us what they did to reduce people’s anxiety and showed us how this and their observations were recorded. There was guidance about strategies staff could use to reduce levels of anxiety if necessary, in individual plans of care. Staff were able to tell us about this in detail. Staff were also clear in their explanation that physical intervention was only used as a last resort, to prevent harm, and for the shortest time possible. They said that it was used only when other measures had been tried to reduce people’s distress. All the staff we spoke with confirmed that they had training in how to intervene physically, if necessary, to ensure people’s safety. However, we noted that most records relating to interventions did not show the duration of any restraint imposed. This meant that the service could not always show that the use of physical intervention and restraint was consistent with people’s rights and best interests. We addressed this with the service manager and registered manager who took action promptly to seek advice from the provider’s behavioural specialist to improve recording.

People told us that they liked the staff who worked with them. One person told us, “Everyone is nice to me.” Another person said, “No, no-one ever tells me off in a cross way.” They told us that they would be able to speak to staff in their care team or to the service manager if they had any concerns about the way they were treated. People had their own copies of ‘easy read’ guidance about their right to be protected from harm and who they could speak to if something happened.

Staff confirmed that they had training to help them recognise and respond to suspected abuse. They recognised that incidents happening between people using

Good

Is the service safe?

the service needed to be reported so that these could be raised with the safeguarding team. Staff were also clear that they would report poor practice but some were not familiar with the term 'whistle-blowing' and what options they had for raising concerns appropriately with other organisations than the provider. One staff member told us, "Poor practice is now being noticed and dealt with, as it occurs."

Risks to people's safety and welfare, both within the service and when accessing the community, were assessed and recorded within their plans of care. There was guidance for staff about how to minimise these. Staff were able to tell us about how they managed specific risks relating to the people they supported. The information they gave us was consistent with records we reviewed. Where incidents happened, records showed that staff reflected on practice and what could have been improved to minimise future risk.

All staff spoken with, with the exception of one new staff member, knew what to do in an emergency. They told us that they had a fire practice that included an evacuation of people living in the service. We understood from our discussions that regular evacuation drills involving people living at the service, would be difficult. We noted that fire detection systems were tested regularly to ensure that they would work in an emergency. We found that there were checks on the safety of the premises to ensure that hazards were addressed promptly.

We checked the balances of two medicines held in stock and found that these corresponded with the records of the amounts held, received and administered. Medicine administration record (MAR) charts were largely completed correctly with only one omission in the records we checked showing that people received their medicines when they needed them. Medicines were audited weekly to ensure they were being managed appropriately.

Medicines were stored safely, with staff responsible retaining keys. Storage temperatures were checked to ensure that the effectiveness of medicines was not impaired by being exposed to extremes of temperature.

MAR charts were annotated to show what action had been taken in the event of an error and also to record when medicines prescribed for occasional use (PRN) had been given. For PRN medication used to alleviate anxiety, protocols were in place. These provided detailed information for staff showing when they should consider its use and how to administer it.

One person wished to administer their own medicines. This was recorded with an assessment of the risk and how this was to be managed. We found that there was an agreed monitoring system in place to ensure the person was supported to take their medicine properly and safely.

Because concerns had been raised with us, we reviewed the arrangements for controlling infection within the service. We observed that liquid soap was available. We noted that there was protective clothing available for staff, and colour coded cleaning equipment for use in different areas of the service such as kitchens and bathrooms. We saw that there were cleaning schedules in place for staff to follow. We noted that staff meeting minutes showed when concerns about cleanliness had arisen that these were followed up with the staff team.

Staff records showed that training in infection control and food hygiene was available and that most staff had completed this. We saw no concerns for the way that food was labelled and stored. The service had been given five stars for food safety and hygiene by the local authority's environmental health department. We concluded that there were suitable arrangements to minimise the risks to people from the spread of infection.

Requires improvement

Is the service effective?

Our findings

Between the last inspection of Westward Farm in June 2014 and this one, we had received concerns that staff were not as well trained as they should be. These concerns suggested that staff had not always been able to support people effectively. We reviewed training arrangements at this inspection.

We discussed with staff how they supported people who may not be able to make decisions for themselves in line with the Mental Capacity Act 2005 (MCA). This is important legislation for staff to understand. Some staff were unclear about this. One staff member asked us what we meant by 'mental capacity'. Staff were also unclear about the Deprivation of Liberty Safeguards (DoLS). These safeguards are used where a service finds someone's liberty may need to be curtailed to ensure their safety and applications need to be made to the local authority. We spoke with the management team about staff's lack of clarity around supporting people to make decisions and promoting their rights and freedoms if their capacity was in doubt. We found that, of the 86 staff listed on the training schedule, only 32 staff were shown as completing training in the MCA and DoLS. We concluded that few staff had been properly prepared to understand their obligations and responsibility in this area.

However, we found that members of the senior support team were clearer about how people's capacity to understand and make decisions was assessed. They recognised that a person's capacity to make specific decisions may fluctuate. They told us how this needed to be taken into account in any decisions about what was in their best interests. This included decisions where people's capacity was temporarily impaired because of distress or anxiety. We noted that the management team had made applications to the local authority for authorisation under DoLS where they deemed this was required and were awaiting outcomes.

Care records contained information about aspects of people's care they found difficult to understand and how staff should try to explain this in order for people to give informed consent. They reflected what course of action was in the person's best interests if they were unable to make the decision but did not always show who had been involved in the assessment of people's capacity.

Staff reflected to us that the skill mix and competence of staff to fulfil their roles had not always been good. For example one commented, "A lot of staff have left and new staff have been recruited. There is a better variety in the experience that staff have now." They said they felt that before, there had been, "…too many young inexperienced staff who were not confident or knowledgeable about how to support people." Concerns about staff skills were reflected in the provider's quality assurance surveys from visiting professionals. One commented that staff excelled at dealing with less challenging and unpredictable behaviours but were not consistently skilled to deal with more complex needs. Another felt that staff did not always have consistent information about the needs of the person when they attended for appointments.

We found that some training the provider identified as needing regular renewal had not been updated. For example, training in epilepsy was due for renewal every two years. We found that this was overdue for 13 members of staff and one of these staff members had not been retrained since 2011.

Some staff had not had training to support people with their mental health or autistic traits despite the service supporting people in these areas. Following a review of an incident in August 2015, the management team had identified that staff should be placed on autism awareness training to commence as soon as possible. We found that training in Asperger's syndrome and mental health was shown as completed by less than half of the staff listed on the training record despite the service accommodating people with needs in these areas.

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

The registered manager had identified that training needed to improve and was reviewing this. Staff told us that they felt training was getting better. One staff member said, "I had a good and thorough induction before I started work and shadowed a senior for seven days." Another told us, "Training has started to improve and we have been given dates to do more training and updates." They went on to tell us they had recently completed training in epilepsy and infection control.

Staff told us that they had completed training in moving and handling, health and safety, fire safety, rights and

Is the service effective?

responsibilities and communication. They also told us how they had access to further qualifications in care and we found that some staff promoted to senior support worker roles were receiving additional training in team leading.

Staff told us that they felt well supported and could go to senior support workers, unit leaders or the service manager if they needed to discuss anything. We found that there were occasional gaps in supervision but generally staff had access to opportunities to discuss their work and performance. Staff told us that there were regular team meetings and they felt able to give their opinions and make suggestions at these meetings. Staff said that the behavioural specialist supported them to reflect on incidents, to see whether anything could be learnt from them. They said that they felt this helped them understand what could be improved and have insight into people's behaviour.

Two people told us that they liked to cook and staff would help them with this. One person said, "I help with cooking... doing fish fingers for tea." We observed the lunch time routine in one part of the home. We saw that people received assistance from staff to eat and drink where this was necessary. For example, one person was encouraged to eat and drink independently using adapted mugs and cutlery. For another person their snack meal was cut up into bite sized pieces and they were provided with cold drinks during the meal. We saw that one person returning from an activity requested a cup of tea and that this was provided promptly.

A staff member explained how the home's communication coordinator supported people using pictures to make choices about what they preferred to eat so that menus could be developed which they would enjoy. Additionally, on the first day of this inspection we saw that a person was shown what was available so they could choose what they wanted. Another person, who enjoyed cooking and shopping, was engaged in discussions with the staff member supporting them about their preferences and making a shopping list.

People were assessed for any risks that they were not eating or drinking enough or were likely to gain large amounts of weight so adversely affecting their health. People's food and fluid intake was recorded where appropriate. Advice obtained from the dietitian about healthy eating had been incorporated into one person's plan of care. Staff were able to give us information about this which corresponded what we had seen in care records. A staff member explained how one person needed a soft diet and ingredients were added to fortify the person's meals. They said this was to increase the person's calorie intake as they were prone to weight loss. We concluded that people were supported to have enough to eat and drink and to enjoy their meals.

One person told us, "Yes I see the doctor if I need to. The staff with me take me to see them." We also found from people's care records that they were supported with appointments for other health professionals. Staff were able to describe how the health needs of two other people were being met and that the doctor or district nurse would visit them at home.

There were guidelines about arranging appointments in a way that would promote people's understanding and cooperation with any treatment deemed necessary. We found that a community learning disability nurse had been involved in drawing up one of these plans about how the person was to access the health care they needed. Care records also showed where people had received support and advice from professionals such as psychology and psychiatric services or speech and language therapists. We concluded that there were arrangements in place to consult with others who could help promote people's health.

Requires improvement

Is the service caring?

Our findings

We found that there was use of 'baby monitors for routine monitoring within the main house at Westward Farm. Transmitters were in people's private rooms and broadcast the sound of what people were going to an area predominantly used by staff, but also accessible to others living in or visiting the service. Our discussions with staff showed that the use of the monitors helped to ensure the safety of staff so that they could summon assistance quickly in an emergency. Records showed that they were also used to monitor people who had epilepsy. However, we considered that this was an invasion of people's privacy by listening in to what was happening whether they were alone or not. We could not see that this had been subject to proper consideration in line with current published guidance about the use of surveillance and whether other, less intrusive arrangements could be made to enable staff to monitor people. We did not find that people had been consulted in order to determine whether they were able to give explicit consent to the use of the system to promote their safety or that of staff.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to tell us considered that their privacy was respected. For example, one person said, "Yes the staff always knock before they come in [to my room] and they ask me if they can come in." We observed that people were able to spend time alone in their rooms if they wished.

One relative had expressed some concern to us that they were not always involved in supporting a person with decisions about their care and were not kept informed. However, we saw that a member of the person's family had signed some parts of the care plan showing this had been discussed with them. This included risk assessment and management guidelines which the relative had signed in April 2015. Most other plans of care showed when family members had been involved in supporting people and we noted that there were internal audits of individual support plans. One of these had identified the need to ensure relatives were encouraged to sign to show they were consulted if they wished to be.

Some people had signed their own records or told us about plans they had agreed to. For example, one person said, "I did agree to my daily plan and each day the staff I have with me remind me of what I have to do." They went on to tell us, "When I moved flat they [staff] bought me down to see it and they asked me if I liked it and I chose the colour of my walls."

Staff gave us examples of how they tried to work with people and find out what they wanted to do. For example, one staff member said, "We encourage people to make their own decisions by giving them a choice and time to answer." Another said, "We get to know people really well…even those who cannot tell us their views. We recognise when they disagree with us by their facial expression or the shaking of their head. We respect their views."

Staff had a good understanding of people's preferences and backgrounds and were able to tell us about these. We concluded that they were sensitive to the way people's experiences and histories might influence what made them anxious or distressed. We also noted that there was clear guidance for staff about how they needed to communicate with people to help them understand information.

For example, there was guidance about the use of 'story boards' and pictures to help people understand and to be involved in choices. We saw that people also had photographs to prompt them about activities and their individual programmes. These served as a reminder of what they could be doing each day and to support them with making choices about this. We concluded that staff tried to encourage people to express their views about their care and support.

One person told us, "They [staff] are my friends." Another person said, "We have a laugh and a joke and if I am feeling cross they [staff] leave me and when I am feeling better I come out of my flat." They went on to tell us that they had helped to choose the staff in their core team who they described as, "...friendly."

We observed good, positive interactions between people and staff. Staff included people in conversations which were warm and respectful. They used reassurance and distraction to good effect when people became anxious. Where appropriate people were encouraged to go into their flat for 'quiet' time but their wishes around this were respected.

Requires improvement

Is the service caring?

We saw that one person, preparing for an outing, was encouraged to do what they could for themselves and to fit the footplates onto their wheelchair before leaving. It was clear they had a sense of pride in completing this with some prompting from the staff member concerned.

People were supported to stay in touch with their families. One person stayed in touch with their family using Skype and staff supported them to arrange appropriate times for this to happen. Another person told us, "They [staff] help me to go and see my family. They take me home for the weekend and bring me back. I like going home but I like to come back here as well." Staff confirmed this and told us how they supported other people to go on visits to their family. This included arranging transport for visits either for relatives to visit Westward Farm or for people to go to their family home. During our inspection staff arranged for a person to see their relative. These arrangements and regular visits were recorded in people's care records when they took place. Staff told us too how they used these visits to speak with family members about the person and what they had been doing.

Relatives' surveys we reviewed showed that they were satisfied with the care that people received. For example, one relative commented, "Our [person] seems happy and that is our number one concern." Another said, "It was the best move we could have made for our young adult." They went on to say that they were very happy and content and felt that the service was making improvements all the time. They commented, "Staff are wonderful."

Although there were some concerns about the stability of the staff team which now needed to be maintained, questionnaires completed by visiting professionals were largely complimentary about the attentiveness of staff. For example, one survey showed that staff were positive, polite and professional. Another commented that there was, "…overall committed and caring staff group."

Good

Is the service responsive?

Our findings

Staff gave us examples of people's individual needs and how they supported people. The information they gave us was consistent with what we saw in individual plans of care, which were reviewed when people's needs changed.

For example, staff told us how one person's epilepsy sometimes adversely affected their welfare. They said that a succession of seizures meant they would need to encourage the person with more rest to ensure their recovery. Another staff member was also able to tell us how a person's gait and balance deteriorated if they became over-tired, making them more prone to falls. They described how the person's core team were encouraging them to take some rest after activities to promote their health and welfare. We observed that, where one person was noted as being quieter than usual, staff checked with them whether they were feeling all right.

Staff were also able to tell us what sorts of things made people respond positively. For one person this included singing along with them with their preferred tunes and we found that this was clearly reflected in their plan of care as a way of engaging with them. One staff member told us, "We are encouraged to treat the people living here as individuals. We get to know the person and how they like to be supported." Another commented, "We get to know people well and work out their daily routine from what they tell us they want to do. We take into account the risks and interests of the person and try to take them out into the community." We concluded that staff were focused on the needs of individuals and recognised differences in how each person needed to be supported.

Some people were able to tell us about the things they liked to do and how they were being involved in activities. One person said, "I have been asked to organise a Halloween do. I am really excited. The staff are going to help me. I am going to make a poster and invite everyone. We will do things like bobbing the apple and wear masks. I love it."

We noted that a visiting professional had commented about the way concerns and complaints were dealt with in the provider's questionnaire. They said that, "There have been a number of issues, most of which have now been resolved." We noted that they said some issues had been dealt with really quickly but that others had not been so promptly resolved. The survey had only been completed in the month before our inspection so the registered manager and provider had not yet had time to analyse the results and develop an action plan showing how they would improve this area.

People using the service and who were able to tell us expressed their confidence that complaints would be dealt with. One said, "I would soon tell [service manager]." They said that the service manager would sort things out for them. Another person said, "If I am not happy or I have a complaint I would tell someone in my core team or [service manager]. They would help me straight away." We saw that people had information about making complaints that was in an 'easy read' format with pictures about how they could go about raising concerns.

In practice we concluded that most people using the service would need some assistance with raising a complaint. Staff recognised the importance of supporting people to raise concerns, or doing this on behalf of people if there were issues about how well someone was supported. A staff member told us, "Complaints are immediately dealt with and the issue is discussed during handover so that it does not happen again."

Requires improvement

Is the service well-led?

Our findings

We found from a review of records and discussions with staff, that notifications of events happening within the home were not always being made to the Care Quality Commission. We found evidence in records of an investigation in response to a safeguarding concern, but a notification of an allegation of abuse had not been made.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We had concerns that some systems for monitoring and checking the quality and safety of the service were not always effective in identifying where improvements needed to be made. This included concerns about the use of electronic monitoring without reference to appropriate published guidance.

We noted that, despite being reviewed after incidents, in one case there was a lack of clarity around the sequence of events in which a person had sustained an injury. We also found that the analysis of records of physical intervention had not identified shortfalls in recording. No remedial action had been taken to ensure the duration of interventions was always recorded. Likewise, the checks had not identified a contradictory fault in the records. This related to recording the size of groups people were participating in when incidents had taken place. The record indicated that a 'large group' activity was less than three people, and a small one was more than three people. This increased the potential for errors in recording and that events could not be properly analysed and learnt from.

The provider's action plan in response to an investigation of an incident in August 2015 showed that additional training for all staff was needed as soon as possible but this had not happened. The majority of staff had not had relevant training for supporting people in line with the Mental Capacity Act 2005. Time limited training for some staff had expired and was not shown as renewed or booked on the schedule we were provided with.

Although there was a check list for ensuring the recruitment processes were followed, this had not been implemented robustly in ensuring that the records required were consistently maintained and that gaps were identified and followed up. In the sample of records we reviewed the checklist identified that all the required information was in place, when there were some omissions from the records of staff employed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager supplied the results of a staff survey completed in June 2015. This indicated that most responses were positive but that some improvements would be welcome. Family members and visiting professionals had also been contacted, using a survey to gather their views.

We noted that there were spot checks taking place. This included a check during the night shift made in March 2015. This check included ensuring that the staff on waking night duty had up to date training in first aid and epilepsy so that they were able to support people properly and safely. We also noted that other checks were made on the safety and quality of the site. For example, one check completed on 3 July 2015 identified actions that were needed to improve. This was followed up on 14 July 2015 to ensure that the identified improvements were made.

Most staff said that the management team were approachable and had an open door policy. The registered manager was responsible for overseeing two separate locations and staff commented that the management team was busy and sometimes not available. We noted from discussions that there was less management support available on site at weekends. However, we noted that an 'on call' system was in place for staff to gain support and advice out of hours if this was needed.

Staff reflected that the service had not always been well-led and that morale had been low. However, the management structure had been revised during 2015 and staff told us they felt that this was helping to improve morale. Staff told us that it was easier to speak to a manager now that a better management structure had been put in place. They said that their unit leader, senior support staff and service manager were approachable and that they felt listened to and supported. One staff member commented, "Staff morale can fluctuate on some days. It has improved and the restructuring has helped."

Requires improvement

Is the service well-led?

Staff we spoke with described team work as good. They told us that they felt their colleagues were supportive. They told us that despite their work sometimes being difficult and stressful they enjoyed it. Those spoken with were enthusiastic and well-motivated.

We concluded that changes within the management structure needed time to embed to ensure stability in the leadership of the service and to drive further improvement in the quality of the service.

We noted that the provider employed additional professionals to supply guidance and support, including a behavioural specialist and speech and language therapist to help ensure staff had access to additional support and advice about best practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered persons had not ensured that staff received appropriate training promptly to meet people's needs effectively and that it was renewed when necessary.** Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People's privacy was not maintained at all times and monitoring measures had not been properly considered.** Regulation 10(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered persons had failed to notify the Commission without delay of abuse or allegation of abuse in relation to persons using the service.** Regulation 18(1), (2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems for auditing the quality of the service were not consistently effective in evaluating and improving practice and ensuring accurate and complete records were maintained.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17(1), (2)(a),(c), (d) and (f)