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Boscobel

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**

Overall summary

This unannounced inspection of Boscobel took place on 24 March 2015.

Boscobel was inspected on 30 September 2014 and found to be in breach of Regulations 9, 21, 23 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The Care Quality Commission (CQC) received an action plan from the provider to outline how improvements would be made. Satisfactory improvements had been made with respect to the breaches in Regulation.

Located in a residential area of Southport and close to the town centre, Boscobel provides accommodation, personal care and support for up to 20 people with a learning disability. Accommodation is available on three floors. On the ground floor there are two shared lounges with a dining room in the basement. The bedrooms are mainly for single occupancy. No passenger lift is available. There is a large back garden and parking to the front of the building.

A registered manager was not in post as they had left the service shortly before our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 told us the staff were caring and respectful, and they felt safe living at the home. Equally, families we spoke with were confident their relatives were safe living at the home and safe in the way staff supported them. Staff understood what abuse was and the action they should take to ensure actual or potential abuse was reported.

Both staff and people living at the home said there was sufficient staff on duty at all times to meet their needs. Effective staff recruitment processes were in place. All the relevant recruitment checks had been undertaken to ensure new staff were suitable to work with vulnerable adults. The status of staff training, supervision and appraisal was unclear from the existing records so the manager, who was new, had devised a new schedule of staff training and support. The staff we spoke to told us they were up-to-date with their training, supervision and appraisal.

People told us they received their medication at a time when they needed it. Safeguards were in place to ensure medicines were managed in a safe way.

Risk assessments and associated care plans were in place for individual risks people presented with. These were regularly reviewed and updated. People had access to a range of health care practitioners when they needed it.

Measures were in place to monitor the safety of the premises, equipment and cleanliness of the environment. People living at the home had the option to attend fire training and one of the people provided for us an accurate account of what they would do in the event of a fire.

The design and layout of the building meant that people with mobility needs were unable to access some areas of the building, such as the basement where the dining room was located. We have made a recommendation regarding this.

People told us they were happy with the food and that drinks were available throughout the day.

Staff sought consent from people before providing day-to-day care, including personal care. Consent in accordance with the Mental Capacity Act (2005) was not recorded in relation to more complex decisions, such as to confirm they were satisfied for the home to manage their personal money. We made a recommendation regarding this.

We observed staff supported people in a kind, caring and unhurried way. Personal care activities were carried out in private. A keyworker system had recently been introduced.

The care records, including assessments and care plans, mostly focussed on the health needs of people. There was limited information about people's social needs. Although a person-centred plan had been completed for people, an action plan had not been developed to outline how people's aspirations and wishes would be met. The person-centred plans had not been reviewed or updated for a number of years. We made a recommendation regarding this.

The manager was making changes to promote a modernised person-centred model of care. This was in the early stages of introduction so it was too early to see the impact it was having for people and for the service.

A complaints policy was in place but was not available in an easy-read format. The manager advised us that no formal complaints had been received. Both people living at the home and their families said they had no complaints about the service. Meetings were held for people so they had the opportunity to express their views about the service. Feedback was also obtained via satisfaction questionnaires.

Audits and checks were established to monitor the safety and quality of the service. Medication audits were undertaken each month. Care plan audits were conducted on a regular basis but they had not identified the issues we noted with care plans. The care records were confusing in terms of the documentation and how it was used. For example, the care plans did not clearly identify a person's needs.

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?

Good

The service was safe.

Relevant risk assessments had been undertaken depending on each person's individual needs.

Staff understood what abuse meant and knew what action to take if they thought someone was being abused.

Safeguards were in place to ensure the safe management of medicines.

Measures were in place to regularly check the safety of the building, equipment and cleanliness of the environment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought the consent of people before providing day-to-day care and support. Consent was not obtained from people for more complex decisions, such as to confirm they were satisfied for the home to manage their personal money.

People told us they liked the food and got plenty to eat and drink.

People had access to external health care professionals and staff arranged appointments readily when people needed them.

Staff said they were well supported through induction, supervision, appraisal and on-going training.

The design and layout of the environment meant that people with limited mobility could not access all shared areas of the building.

Is the service caring?

Good

The service was caring.

Staff were caring and kind in the way they supported people. They treated people with dignity and respect. They ensured people's privacy when providing support with personal care activities.

People could have visitors when they wished.

A keyworker system had recently been introduced by the manager.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

People's health care needs were being well met at the home.

The approach to supporting people with a learning disability was not always in keeping with the spirit of a person-centred model of care.

People told us they knew how to raise any concerns or complaints about the service. People told us they had no complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

A new manager was in post at the home was promoting a modernised person-centred model of care. It was too early to see the impact this was starting to have on the service.

Staff spoke positively about the changes the manager was making.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Quality monitoring processes, such as audits were in place. Medication audits were conducted each month. Care plan audits were undertaken regularly but they had not identified the issues we found with the care plans.

Boscobel

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 24 March 2015 and was unannounced.

The inspection team consisted of an adult social care inspector and an expert by experience with expertise in services for people with a learning disability. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We usually request a Provider Information Return (PIR) but had not done so prior to this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service and health care professionals who visited the home on a regular basis to see if they had any information about the service.

During the inspection we spent time with seven people who lived at the home and spoke with three family members by telephone. We also spoke with the home manager, a senior carer and two care staff.

We looked at the care records for three people living at the home, three staff recruitment files and records relevant to the quality monitoring of the service. We looked round all areas of the home, including people's bedrooms, bathrooms, dining rooms and lounge areas.

Good

Is the service safe?

Our findings

The inspection in September 2014 found the service was in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to staff recruitment. We looked at the personnel files for three recently recruited members of staff. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff. Photographic identification and the interview record were retained in the personnel files. We spoke with a member of staff who was recently recruited. They described a thorough recruitment process and said they did not start the job until all their recruitment checks had been completed.

The service was found to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 at the last inspection. This breach was mainly in relation to a risk assessment and care plan not being in place for a person presenting with a serious risk both within the home and within the community. Satisfactory improvements had been made with respect to this breach of regulation.

People living at the home told us they felt safe living there. However, one of the people spoke to us about feeling bullied by another person living there. The person said, "I feel safe here apart from one person who lives here who sometimes gets out of control and hits out, about once a week usually. The staff know about this but everyone else is okay." We discussed this with a senior member of staff and the manager. They were aware of who the person was being referred to. They told us the person has raised their voice to other people but had not hit other people for the last two years. The member of staff described the structured approach they used to prevent such an incident happening and the action they took to de-escalate an event once it had occurred. The member of staff said that a medicine with calming properties was offered to the person as a last resort if de-escalation was not successful. They said this medicine was rarely used.

We spoke with family members who said Boscobel was a safe place for their relative to live. One family member did raise concerns about the diverse age range and needs of people living at the home and worried this could mean their relative was more vulnerable. The family member said, "Boscobel is safe, yes, but we don't feel that people with alcohol problems should be in the same place as my [relative]…this is the only worry we have."

The age range of people living at the home was broad with the youngest person in their early thirties and the oldest person in their late seventies. This meant the staff were supporting people with a diverse range of needs, social interests and abilities associated with their age. We did not observe or hear anything to suggest that the broad age range of people had an impact on individual vulnerability.

We spoke with staff about their understanding of adult safeguarding. They told us a safeguarding policy was in place and they had access to it if needed. Staff confirmed they were up-to-date with adult safeguarding training. We observed staff supporting people in a kind and considerate way throughout the day. Staff were constantly checking on people and they regularly monitored the lounges.

Fifteen people were living at the home at the time of the inspection. Three care staff were on duty during the day. The manager was also on duty during the day. Two care staff worked at night; one staff was on waking night duty and one undertook a sleep-in but could be woken at any point if required to provide support. People living at the home told us this staffing level was sufficient to meet their needs. Equally, staff confirmed that they believed the staffing levels were adequate.

We found the paperwork in relation to risk assessment and associated care planning was confusing and fragmented. This meant it took a while to locate the information we were looking for because of both repetition and the inclusion of unnecessary paperwork in the care records. We were concerned that staff may not be able to locate a specific risk assessment or care plan promptly if they needed to. We discussed this with the manager who said they would look into streamlining and simplifying the paperwork.

Despite this, the four care records we looked at and from discussions with the manager, we could see that as risks were identified they were addressed promptly. These mainly related to risks associated with physical health needs. Risk assessments and associated care plans were consistently reviewed on a monthly basis and revised depending on people's changing needs. Staff we spoke with had a good understanding of each person's risks. They

Good

Is the service safe?

provided examples of how they had managed risks and we noted this was in accordance with people's care plans. The majority of the risk assessments and care plans were signed by the person they were about or their representative.

A process was established for recording and monitoring accidents. There were very few accidents recorded and the few we did see related to falls people had experienced. No accidents were recorded throughout January and February 2015. A separate process was in place for recording and monitoring incidents that did not involve an accident. No recent incidents had been recorded.

Medicines were held in a secure trolley attached to the wall in the basement. Medication that required refrigeration was stored in a dedicated fridge. Although a thermometer was located in the fridge and showed the fridge temperature was appropriate, the daily temperatures were not formally checked and recorded. This meant there was no formal structure in place to check the fridge temperatures were within the correct range. We discussed this with the manager who said they would start recording these checks straight away.

We checked the medication administration records (MAR) for three people. These had been appropriately completed and signed each time medicines were administered. Body maps were used to show were topical medicines (creams) should be applied. Appropriate measures had been taken to support people to administer their own medicines. For example, a risk assessment had been completed for a person who looked after and applied their own topical medicines. Another person administered some of their medication with supervision and this was clearly indicated on the MAR and signed for. A person had recently received covert medication and this has been agreed with the person's family, social worker and GP in their best interest. The manager confirmed that the administration of covert medication had been discussed with the pharmacist. Administering medicines covertly means that medication is disguised in food or drink so the person is not aware they are receiving it.

Arrangements were in place which demonstrated medicines were checked in and disposed of safely. Senior care staff were responsible for the management of medicines. The manager advised us that all care staff undertook medication training.

We looked at the medication policy and noted it did not capture all the guidance outlined in the NICE guidance for managing medicines in care homes, including guidance on reporting errors, medication reviews, mental capacity and staff training. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care.

One of the people who lived at Boscobel showed us around the home. The home was clean and clutter free. A building risk assessment had been completed on 3 March 2015. The testing of portable appliances was undertaken in July 2014. Arrangements were in place for the disposal of waste. We observed that a schedule was in place for cleaning the building.

An internal fire risk assessment was completed in January 2012 and was reviewed in January 2014. A periodic assessment by the fire service in April 2014 identified requirements for improvement. The manager confirmed the fire service had since revisited the home and were satisfied that the requirements had been addressed. Records informed us that the fire alarm was last tested in January 2015. The manager told us that people who lived at the home could participate in the fire training and fire drills if they wished. The person who showed us around the home was clearly able to describe the procedure for evacuating the building if the event of the fire alarm activating. An evacuation list was located in the foyer that clearly indicated the needs of each person in terms of the support they would need to exit the building. A procedure was also displayed indicating what to do in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

The service was found to be in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 at the last inspection. This was in relation to staff supervision and appraisal. The manager advised us that the existing records did not made clear the status of staff supervision and appraisal. The manager had developed a plan for 2015 and we could see that supervision was planned to take place every three months and an annual appraisal for each member of staff. Staff we spoke with confirmed they had received supervision recently. The personnel records we looked at showed that the manager had started to undertake supervision with the staff.

People living at the home told us the staff looked after their health care needs and arranged for them to see a doctor, nurse or other health care professional if they needed it. A person told us that they were due to have an operation in hospital. They said, "I am scared about this but do feel I have been given good staff support and I have now made my decision to have the operation." Equally, family members we spoke with said their relative's health care needs were well looked after.

From our conversations with staff it was clear they had a good understanding of people's health care needs and responded to those needs in a timely and effective way. This was confirmed by our review of the care records as they showed there was strong focus on meeting people's health care needs. There was good detail in the assessments and care plans about each person's health care needs and how these needs were being met.

We spoke with two members of staff who were recently recruited. They described a good induction whereby they had between two and five days shadowing an experienced member of staff. During this time they said they spent time with the people living there getting to know their needs. They told us they received good support from the manager who responded promptly to any questions they had. The manager confirmed that new staff completed an induction pack and this was then assessed by the manager.

The manager had very recently started in the role and told us it was unclear from the records whether staff training was current. In response to this the manager had arranged for staff to receive the full range of training the provider (owner) required them to undertake for their role. The manager provided evidence to confirm that training through an external company had been arranged to take place between April and June 2015 in topics such as fire safety, epilepsy, dementia, infection control, first aid and the Mental Capacity Act (2005). Adult safeguarding training and lifting and handling training had also been arranged but the staff we spoke with during the inspection confirmed they had completed this training within the last three years.

We asked people living at the home their views of the food and access to drinks throughout the day. The views were mixed. Most people were satisfied with the food. One person said, "The food is okay here." Another person told us, "It is always the same food – just different days." We were invited by people living at the home to join them for lunch. We found the food to be satisfactory. We noted from the minutes of the 'resident's meetings' that the food and menus were discussed at each meeting. This meant people living at the home were provided with the opportunity to express their views about the food. We observed throughout the day that people had access to regular drinks. People's weight was monitored on a regular basis to check for any fluctuation. Most people's weight was last checked in December 2014.

Throughout the inspection we heard staff seek people's consent before providing day-to-day support and care. For example, we heard staff ask people if they wished to take their medication or participate in an activity. We noted from the care records that people had signed their care plans when they were first developed.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) for the people who lacked capacity. This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. The majority of people we spoke with clearly had capacity to make decisions about their day-to-day care and support needs therefore we did not see many decision-specific capacity assessments in the care records. We did see one mental capacity assessment for a person completed in July 2012. However, this was a generic assessment and was not identify the specific decision the person was being assessed for.

We could see from the care records that some people had given verbal consent to staff managing their medication

Requires Improvement

Is the service effective?

but evidence of this consent was not in all the care records we looked at. People's personal money was being managed by the home and people told us they received 'pocket money' when they needed or asked for it. Although people told us they were happy for their money to be managed by staff, there was no record to show how they had consented to this arrangement.

The staff we spoke with had a broad understanding of the Mental Capacity Act (2005) and DoLS and how the principles applied in practice. However, we did find that management and staff were not aware of the need to record how people were supported to make specific and important decisions, such as how their money is managed.

We recommend that the provider considers current guidance in relation to the Mental Capacity Act (2005) and takes action to update its practice accordingly.

None of the people living at the home was subject to a Deprivation of Liberty Safeguard (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We observed people leaving the building throughout the day. Staff told us people who would be unsafe outdoors on their own showed no interest in going out alone. They said if a person insisted on going out then a member of staff would go with them.

We observed that two people shared a bedroom. This was a recent arrangement and the manager said that each of the people previously had their own bedroom. The manager thought the reason for this sharing of a bedroom was to accommodate another person who, due to deterioration in their mobility, needed a bedroom on a ground floor. The manager confirmed the people and their families had agreed to both people sharing of a bedroom in order to release a single bedroom on the ground floor. Appropriate facilities were available in the bedroom to ensure each person's privacy and dignity.

The rationale behind two people sharing a bedroom led us to look at the environment and how suitable it was to meet people's needs and promote their independence. The building does not have a passenger lift or stair lifts to accommodate people with limited mobility on the floors other than the ground floor. Therefore people who could not use stairs needed to be accommodated on the ground floor. This meant they could not access facilities on other floors. For example, the dining room was located in the basement and was accessed via a steep set of narrow stairs. People with limited mobility who had a bedroom on the ground floor therefore could not have their meals in the dining room with other people even if they wished. We discussed with the manager the design of the building in relation to the needs of the people living there, some of whom were older adults with mobility needs. We discussed the appropriateness of moving a person from their established bedroom in order to accommodate another person. The manager said they recently had enquiries about people moving to the home but could not accommodate them due to their mobility needs. We noted that the statement of purpose (information about the home) did not mention the home would be unable to accommodate people with mobility needs.

We recommend that the provider considers current guidance in relation to the design and adaptation of the environment for older people.

Good

Is the service caring?

Our findings

People living at the home were very happy with the care and support provided by staff at Boscobel. A person told us, "The staff are very kind. They are nice to me." Equally, family members we spoke with were satisfied with the care their relatives received. A family member said to us, "He is well cared for. We visit a lot. We are always made to feel welcome. It [the home] has a family atmosphere." Another family member told us, "It's a wonderful place. Everyone, staff and residents, speaks with respect to each other." Families told us they could visit their relative at the home anytime they wished and were always made to feel welcome.

Throughout the inspection we observed staff calling people by their preferred name and supporting people in a caring, respectful and dignified way. We arrived early in the morning and some people were up and sat in the lounge. Staff were in the lounge too and we heard them speak to people in a friendly and kind way. We observed staff explaining to people what was happening prior to providing care or support. A person had their own unique way of communicating through the use of their own language. Staff understood their form communication and provided support when the person requested.

There was a calm atmosphere in the home. Throughout the inspection we observed staff supporting people in an easy going and unhurried way. The staff we spoke with demonstrated a warm and genuine regard for the people living there. We observed a positive and on-going interaction between people and staff. We heard staff explaining things clearly to people in a way they understood. Personal care activities were carried out in private. People did not have to wait long if they needed support.

One of the people living there showed us around the building. They did not show us into other people's bedrooms because they said they "did not have permission" from the people. The person said staff always knocked on their door and waited for a response before entering the room. They told us staff helped them to "decorate and make their room nice". The person said people could have keys for their bedrooms if they wanted to lock their room. The person told us they no longer had a key or wanted a key for their bedroom as they kept losing the key.

Although most care plans had been signed by the person when it was first developed, there was limited evidence in the care records to suggest that people or their representative were involved in on-going discussions about their care. Families told us the manager and staff were approachable and communicated well with them regarding their relatives changing needs. A key worker system had recently been introduced by the new manager. A key worker is a member of staff responsible for one or more persons. The role involves ensuring the person's support and care meets their needs. Often this role involves discussing and reviewing the person's care with them. The manager advised us that the keyworker role was not fully embedded in practice yet.

Various files were stored in the basement and notices for staff were displayed on the wall in the basement to next to the dining room. Some of the notices were not conducive to a homely, person-centred and caring environment. For example, there was a notice about bed changes and another notice in large writing advising staff to complete the 'bowel book' before finishing their shift. We did not think these types of notices were appropriate for display in a shared area of the home and highlighted this to the manager. The notices were removed immediately. Notices were displayed in the foyer for people living there, staff and visitors, such as what to do in the event of the fire. These notices could be more accessible to people if they were in an easy-read pictorial format, including a larger font.

The manager confirmed that they had access to the local advocacy service should any of the people living at home need to use it.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy living at Boscobel and that the service met their needs. People had very different needs in terms of independence and some people went out regularly in the community. For example, one person had a job in the local community and other people attended day centres or community groups. Some people went out on their own as they had friends and contacts in the local community.

We spoke with one person who told us about a number of community activities they participated with, including swimming and rambling. Other people spent their day in the home but said they sometimes went for walks with staff or staff went with them to visit their relatives. People told us they helped with household tasks. For example, one of the people put the bins out each week. A person told us, "Normally I stay in…do my washing or help staff or I walk into town. I don't need any support. I can come and go as I please but I let the staff know if I am going out."

A family member we spoke with was happy that her relative's needs were being met. They said, "My [relative] has lived at Boscobel for about four years. Her previous care home closed down. She spends most days watching the other residents or watching television and seems very content with this. The previous places she lived in were old fashioned institutions." Another family member told us they could visit whenever they wished. The family member said, "All of my family turn up unannounced. We are always pleased that my [relative] is clean, tidy and well dressed. I know that she is happy."

We were advised that an activities coordinator was in post. People living there told us that in previous years they went out as a group on coach trips in the summer to places like the safari park and Blackpool. All the people we spoke with said they enjoyed these trips. The manager told us that a mini-bus had been hired in the summer for two weeks to facilitate the trips. This meant trips to places of interest that were a distance away could only take place within the two week timeframe. We did discuss with the manager that this approach was not in keeping with the spirit of person-centred model of care. 'Person centred' means the individual needs of the person and their wishes and preferences are at the centre of how the service is delivered.

We asked people throughout the inspection whether the staff accommodated their preferred daily routine. Some people said Boscobel was a vast improvement on the previous places they had lived. For example a person said to us, "I used to live in Liverpool in about five other places. Some were shut down. I like it here. I have always ended up living with older people so I am used to it now. I wanted to come and live here." Another person said, "I came here in 1991. I had no choice then but I am happy here and things are good." All of the people we spoke with had been used to a residential model of care and had a very limited knowledge and low expectations about alternative choices in terms of where and who they lived with.

People told us they could get up in the morning and go to bed at whatever time they wished. The staff we spoke with had a good understanding of people's background history, preferred routines and likes/dislikes. However, the knowledge staff had about people's individual preferences and interests was not effectively captured in the care records we looked at. Some people had an overarching person-centred plan (Essential Lifestyle Plan) in place. This had been completed sometime back and there was limited evidence to indicate that the person or people close to the person, such as family had contributed to the person-centred plan. In addition, an action plan (a fundamental part of an Essential Lifestyle plan) had not been developed stating who would do what and by when. There was no evidence in place to suggest the plans were subject to regular reviews and updates.

Overall, the care records we looked at, in particular the day-to-day care plans, largely focussed on the physical and medical needs of people and there was minimal information to indicate how people's social needs were being met. The majority of the care plans were not actually care plans but a running commentary on people's appointments with various professionals. For example, a person's care plan was updated in December 2014 by stating 'diabetic check'. The update in January 2015 stated 'bloods taken' and the update in February 2015 indicated the person had seen their GP with back pain. A document in the care records showed that care plans were reviewed each month. 'Care plan updated' or just 'updated' were the regular phrases used for each review. There was no indication that the person was involved in these reviews

Requires Improvement

Is the service responsive?

and no record of how the person had spent the month. Again, we discussed with the manager that this approach was not in keeping with the spirit of a person-centred model of care.

Staff we spoke with told us they promoted people's independence. They said people were encouraged to see to their own laundry and tidy their bedrooms. However, the care records did not capture this information about encouraging independence. In addition, people did not appear to have a choice of managing their own personal money and it was not clear why they had not been offered the option to do so. We noted that the Statement of Purpose (information about the home) said that there was 'access to a locked cashbox' in the bedrooms so facilities were available for people to secure their money in their room. One of the people told us they did not know the balance of their personal money. The manager advised us that a person had recently started to pay for their taxis rather than staff doing it for them.

We recommend that the service considers current best practice guidance in relation to person-centred planning and support and updates its practice accordingly.

People living at the home that we spoke with said they had no concerns or complaints about the home, the staff or the care they received. A complaints policy was in place but we did not see this in an easy-read format. The manager advised us that no formal complaints had been received about the service. The manager said there was an open door policy and if people or families raised a concern then the matter was addressed promptly. People living at the home told us the manager was approachable if they were unhappy about something.

Requires Improvement

Is the service well-led?

Our findings

The inspection in September 2014 found the service was in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to not informing CQC of events the service was required to notify us of. We checked the notification submitted to CQC alongside the incident reports held at the home and noted that CQC had been appropriately notified of events that had occurred.

A registered manager was not in post as they had left the service just prior to our inspection. The deputy manager had taken on the role of manager.

We asked people living at the home and families their views of how the home was managed. People said they were happy with the management of the home. A person said to us, "The managers are good. We think they are doing a really good job. They are easy to talk to. We are happy here." A family member told us, "Yes, we feel it is well led especially compared to other local care homes we know of."

We asked the manager how people living at the home were involved in the running of the home and any service developments. The manager informed us that people were involved in the recruitment of new staff. They were involved in interviewing potential staff and showing them around the home.

In addition, people told us meetings took place at the home. Most people were positive about the meetings but one person said to us, "We talk about food but we don't think we are listened to…nothing changes." The manager confirmed that conversations with this person about the food were on-going. The manager confirmed these monthly meetings were chaired by staff rather than people living at the home. The available minutes suggested the meetings did not take place each month in 2014. We looked at the most recent sets of minutes; March 2015, October 2014 and November 2014. People living at the home had the opportunity to discuss recreational activities, food and drink provided at the home. Other matters, such as the introduction of keyworkers were discussed at the March meeting. This showed that the manager had provided people living at the home and their relatives with a forum to share information about developments within the home. It was unclear from the minutes whether action had been taken in relation to issues raised. The manager confirmed identified actions had been addressed but agreed to include the action taken in future minutes.

We looked at the feedback people had provided about the service, which was received in the form of completed 'Resident's questionnaires' and 'Relative's questionnaires'. The questionnaires were well constructed and in plain English. They asked relevant questions about the service. Overall, the feedback received about the service was positive. We noted some negative comments on the feedback survey. For example we saw recorded, "Would like to get out more….activities poor…would like to follow other pursuits." It was unclear whether this had been followed up and action taken.

We spent time discussing with the manager the model of care used at the home. Although the way staff engaged and supported people on a day-to-day basis showed a person-centred attitude, the care planning and elements of practice, such as choice about how people's personal money was managed and the promotion of independence, was not in the spirit of a person-centred approach. There was very little information in place to show that people were at the centre of their care and had the opportunity to express and pursue their dreams and aspirations. The manager was aware of many of the issues we raised and was taking measured action to change practices.

We asked staff about the key achievements and key challenges of the service. Staff told us the manager was very supportive and approachable. A member of staff said to us, "The manager is good. She has always got time to speak to you and is always at the end of the phone if you need advice." Staff told us the service was going through some change to modernise it but some staff were less keen on the changes. Some of the changes we were told about included the introduction of a key worker role leading to more responsibility and accountability for care staff and promoting the independence of people living at the home. The manager advised us she had plans in place to support the individual needs of staff with adapting to the changes. For example, the manager organised the staff rota to ensure staff who were reluctant with the changes worked alongside who were embracing the changes.

Meetings were established for the staff team and the manager confirmed she intended to hold them every three months. We could see from the minutes that a meeting

Requires Improvement

Is the service well-led?

took place in December 2014 and February 2015. The meetings provided an opportunity for open communication, the sharing of any relevant information and to confirm expectations of the staff team.

We asked staff about whistle blowing. They were aware of what whistle blowing meant and said a policy was in place at the home. Staff said they would have no hesitation in raising any concerns with the manager.

We looked at a range of policies within the policy folder. The policies were produced by an external company and had been adapted to reflect the care provision at the home. We noted they were produced in 2009 and asked about more recent updates. The manager advised us that when a policy is revised then the company sent it through. We did think that five years was a long time without a policy being reviewed and the manager agreed to look into this.

The manager undertook a range of routine audits at the home to check on the quality and safety of the service. These included medication audits completed each month. The last one was undertaken in February 2015. The most recent health and safety audit took place on 16 March 2015. Care plan audits were conducted regularly. We noted these were very much a 'tick box' approach to audit; checking content and process rather than the quality of the information. We found the care records disorganised and difficult to navigate. In particular, there was a lack of clarity in the care plans between actions and needs. This was not being identified from the audit process. We highlighted this to the manager at the time of our inspection.

It was clear that the manager was taking into account safety alerts circulated to homes. For example, had ensured the safe storage of thickeners for fluids following receipt of a recent safety alert regarding risks associated with consuming thickener.

Although it was clear the new manager was making positive changes, it was too early to fully see the impact these changes were having in developing the service in a person-centred way.