Voyage 1 Limited

Trinity Vicarage Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced comprehensive inspection that took place on 3 April 2017.

Trinity Vicarage Road is a registered care home providing care and support for up to four younger adults with learning disabilities or autistic spectrum disorder. Trinity Vicarage Road is a detached two bedroomed house with an adjoining bungalow and self-contained flat, all of which share a small back garden. The property is located in a residential cul-de-sac within walking distance of the town and other facilities. At the time of our inspection there were three people using the service.

The service had a registered manager. 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 risk of harm at the service because staff knew their responsibilities to keep people safe from avoidable harm and abuse. Staff knew how to report any concerns that they had about people's welfare.

There were systems in place to manage risks and this helped staff to know how to support people safely. Where risks had been identified control measures were in place. However, these were not consistently followed.

There were enough staff to meet people's needs based on the staffing rota. Staff told us that these staffing levels were not always provided. Relatives told us that there was a high use of agency staff and this concerned them. The provider has safe recruitment practices. This assured them that staff had been checked for their suitability before they started their employment.

There were plans to keep people safe during significant events such as a fire. Equipment such as fire extinguishers were checked to ensure that they were safe to use. Evacuation plans had been written for each person to help support them safely in the event of an emergency.

People received their medicines and were supported with this. We found that medicines were not always stored safely and creams were not consistently dated when they were opened. Staff had been trained to administer medicines and had been assessed for their competency to do this.

Staff received support through a structured induction. There was an on-going training programme to ensure staff had the skills and up to date knowledge to meet people's needs. Staff had not been supervised regularly. However, most staff felt that they could approach their manager.

People did not always receive sufficient nutrition and hydration. Where one person had been identified as

being at risk of malnutrition, supplements that had been prescribed were not given. Guidance from health professionals was not recorded accurately to ensure that all staff were following this. People accessed health professionals. Where monitoring of a health condition was required this took place. However, where guidance suggested that medical advice was sought this had not been done.

People were supported to make their own decisions. Staff and managers had an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We found that assessments of mental capacity had been completed. Staff told us that they sought people's consent before delivering their support.

People were involved in decisions about their support. We saw staff treating people with respect. Staff treated people with kindness and compassion.

People were not always supported by staff who knew them well. They had care plans that provided information about them so staff knew what they liked and enjoyed. However, not all staff knew this information as they had not read the care plan. People were encouraged to maintain and develop their independence. People took part in activities.

People and their relatives knew how to make a complaint. The provider had a complaints policy in place and a system called 'See something, say something' to encourage people to raise concerns.

People's relatives and staff felt that a lack of consistency in the management team had impacted on communication and staffing. Feedback had been sought in relation to the quality of the service. However, relatives and staff felt that they were not always listened to.

Systems were in place which assessed and monitored the quality of the service and identified areas for improvement. Some areas of concern that we found during our inspection had not been identified.

The service was led by a registered manager who understood their responsibilities under the Care Quality Commission (Registration) Regulations 2009.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were protected from abuse and avoidable harm by staff who knew their responsibilities for supporting them to keep safe.

Risks to people had been identified and assessed. Guidance for staff on how to keep people safe was not consistently followed.

There were sufficient numbers of staff identified on the rota to meet people's needs. However, staff told us that these numbers were not always in place. The service followed safe recruitment practices when employing new staff.

People received their medicines and were supported with this. Medicines were not always stored appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received support from staff who had the necessary knowledge and skills. Staff had not been supervised on a regular basis. They did feel that they could approach their manager.

People were encouraged to make decisions about their support and day to day lives. Staff asked for consent before they supported each person.

People were not always supported in line with guidance from health professionals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion from staff. Their privacy and dignity was respected.

Staff interacted with people in a caring, compassionate and kind manner.

People were involved in making decisions about their support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs had been assessed. Care plans provided detailed information for staff about people's needs, their likes, dislikes and preferences. Staff had not always read these.

People were not always supported by staff who knew them well. People did participate in activities. Records showed that these were sometimes very limited.

There was a complaints procedure in place. People's relatives felt confident to raise any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was an audit system in place to measure the quality and care delivered and so that improvements could be made. These had not identified all of the concerns that we found during our inspection.

People's relatives felt that a lack of consistency in the management team had impacted on communication and staffing.

People and their relatives had been asked for their opinion on the quality of the service that they had received. However, relatives and staff did not always feel that they were listened to.

Trinity Vicarage 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 inspection took place on 3 April 2017 and was unannounced. The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for someone who used this type of service.

Before our inspection, we reviewed the Provider Information return (PIR). The PIR is a form that asks the provider to give some key information about what the service does well and improvements they plan to make. We also reviewed information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service. We also contacted Healthwatch (the consumer champion for health and social care) to ask them for their feedback about the service.

We reviewed a range of records about people's care and how the service was managed. This included two people's plans of care and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service and policies and procedures that the provider had in place. We spoke with the team leader, a registered manager from another service, three care workers and a visiting health professional. The registered manager was on leave at the time of the inspection. We spoke with them following the inspection. We also spoke with the chief operating officer and the managing director following the inspection.

We spoke with three people who used the service, however due to communication needs it was not possible to seek detailed feedback from them. We also spoke with relatives for all three people who used the service. This was to gather their views of the service being provided. We observed staff communicating with people who used the service and supporting them throughout the day.

Requires Improvement

Is the service safe?

Our findings

People's care plans included assessments of risks to their health and well-being. We saw that risks associated with people's support had been assessed and reviewed. Risk was considered in relation to each area of care and if there was a need for a more detailed assessment to identify control measures this had been completed. However, we found that staff were not consistently following the control measures that had been identified. For example, we found that in order to keep one person safe from harm all liquids needed to be locked away. During our inspection we found that there were liquid products that were out on the kitchen side that could present a risk to the person. We discussed this with staff and they moved the products to a locked cupboard. A health professional told us, "They are not taking full precautions to protect [person's name]." This meant that people were not consistently being protected from risks associated with their care.

People's relatives told us that there appeared to be enough staff on duty to meet people's needs safely. However they told us that there were not enough people employed to provide this care and agency staff were used on a regular basis. One relative said, "The use of agency staff is a concern we came to pick [person's name] up two weekends ago and they were struggling. We took [person's name] away to relieve the pressure." Another relative commented, "It is very difficult to say if there are enough staff." Staff told us that there were not always enough staff on duty to meet people's needs safely. One staff member said, "At the weekends it can be hard to cover all of the shifts. There can be one member of staff less on shifts." Another staff member said, "There are enough staff on each shift unless someone calls in sick." One staff member said, "There have been occasions where cover has not been in place but very few." A health professional told us, "We were told that we could not see [person's name] on their own today as there were not enough staff." They explained that the person required support from staff for the appointment and this had been provided so the person could attend their appointment. We discussed this with the registered manager from another service and a team leader. They told us that all shifts were covered with the required number of staff. They acknowledged that agency staff were used. However, they advised that wherever possible the same member of staff from the agency was used so that they knew the service and the people who lived there. The rota confirmed that agency staff had been used regularly and the same members of agency staff had covered the shifts. We looked at the rota and this showed that the required numbers of staff that had been assessed to be needed were on duty.

People received their medicines and were supported with this. A relative told us, "There was a change to [person's name] medicines on the doctor's advice." The provider had a policy in place which covered the administration and recording of medicines. However we saw that this was not always followed. We found that creams were not always dated when they were opened. This is important to make sure that they are used in line with the manufacturer's guidelines. We also found that cream for one person was stored in the fridge in the kitchen without being stored in a separate container. This would make sure that it could not be mistaken for food by a person using the service and used in error. We observed people taking their medicines and saw that staff followed the policy.

Staff told us that they were trained in the safe handling of people's medicines and records confirmed this.

One staff member said, "We do our online training and then are observed three times to make sure we know what we are doing." Staff could explain what they needed to do if there was a medication error and this was in line with the policy. Some people had prescribed medicines to take as and when required, such as to help with any pain that they had. We found that there were not always guidelines in place to identify when it was appropriate to use these. A health professional raised a concern with us about one person's as required medicine being administered. They told us that they would implement guidance and it would be administered under their guidance. They told us, "This should not be administered without a protocol. Staff were not aware of that." We looked at the medicine administration records and found that these had usually been completed correctly. We did find that there was a gap on the records. The senior in charge of medicines told us that they would look into this.

People's relatives told us that they felt that people were usually safe while they were receiving care from staff. One relative said, "[Person's name] is safe. There has been the odd incident. You need eyes in the back of your head. I have never felt [person] is unsafe." Another relative commented, "There is no problem on that side. [Person's name] is safe."

People were protected from abuse and discrimination because they were supported by staff who knew their responsibilities to keep people safe from avoidable harm and abuse. The provider had guidance available to staff to advise them on how to report any concerns about people's safety. Staff we spoke with had some understanding of types of abuse. However some staff required prompts to identify what might be something they should be concerned about. All staff we spoke with told us that they would report any suspected abuse immediately to the registered manager or external professionals if necessary. One staff member said, "I would report it to a manager if I was worried." The actions staff described were in line with the provider's guidance. Staff told us they thought they had received training around safeguarding adults. Records we saw confirmed that most staff had completed this training.

Where someone had behaviour that may be deemed as challenging plans were in place so that staff responded consistently. The plans identified triggers and ways to support the person to diffuse the situation. Staff told us that they were confident in following these plans. This meant that risks associated with people's behaviour were managed to help them to remain safe.

People could be sure that staff knew how to support them to remain safe in the event of an emergency. This was because there were plans in place so that staff knew how to evacuate people from their homes should they need to. Each person had a personal evacuation plan which was tailored to their needs and the support that they would require in the event of an emergency. There were also plans in place should the home become unsafe to use, for example in the event of a flood. This meant that should an emergency occur staff had guidance to follow to keep people safe and to continue to provide the service. We saw that checks were carried out on the environment and equipment to minimise risks to people's health and well-being. This included checks on the safety measures in place, for example, fire alarms, as well as the temperature of the hot water to protect people from scald risks. Records showed that fire drills had taken place.

The provider had systems in place to report and record any incidents or accidents at the service. Staff we spoke with knew how to apply these. We saw that details of any incidents or accidents were reviewed including actions that had been taken and recorded on a care management system so that actions could be monitored. We saw that the registered manager notified other organisations to investigate incidents further where this was required such as the local authority. This meant that the provider took action to reduce the likelihood of future accidents and incidents and to reach satisfactory outcomes for people.

People were cared for by suitable staff because the provider followed safe recruitment procedures. This

included obtaining two references that asked for feedback about prospective staff and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. We saw within staff records that these checks had taken place.

Requires Improvement

Is the service effective?

Our findings

People were supported to access health care services. However, where guidance was given by health professionals this was not always recorded fully or implemented. We found that guidance had been put in place about how to support one person with regards to their eating and drinking. This information had been reviewed by a health professional. The updated information had not been included in the care plan or a note made in the plan to refer staff to the updated guidance. A health professional told us, "I am not sure that staff are giving a fork mashable diet. They told me that [person's name] had been to eat at [a restaurant chain]. I am not sure what they could have eaten there that was fork mashable. One staff member was blending the food. [Person's name] does not need this doing." This meant that staff were not following the correct or the most up to date guidance.

We found that staff had raised concerns about people's health appropriately. However, staff were not implementing recommendations fully. A health professional told us, "We prescribed supplements. They should have been picked up on Tuesday and weren't. [Person's name] has lost 8.5% of body weight. They lost another kilogram last week." A relative told us, "[Person's name] has lost lots of weight. They are looking emaciated." The health professional explained that there were a range of professionals involved with the person in order to support them. We discussed this with the managing director and the chief operating officer. They told us that the supplement had now been picked up, and were not ready for collection on the initial day that they should have been collected. They also confirmed that the person's care plan now had the correct information in and staff had been made aware of this.

Relatives confirmed that people did have access to health professionals but felt that they were not always supported by staff who knew them well and were not confident all information was recorded. Relatives also felt they were not asked for their input. One relative said, "I don't get told about appointments. [Person's name] was diagnosed with osteoarthritis. I only found out about the appointment after it happened. We would have asked so many questions. I am angry as [person's name] went with a staff member that they did not really know. I don't know if anything is even recorded." Records we reviewed confirmed that people were attending regular appointments with health professionals such as an optician, a chiropodist and the dentist. We saw that where someone had a health need that needed monitoring records were kept for this. However, actions that may be needed were not always recorded. For example, one person had their bowel movements monitored. Guidance identified that if the person did not have a bowel movement for a specified number of days medicine should be given to encourage this and if this did not have the desired result then the GP should be contacted. The records indicated that the person had not had a bowel movement for a number of days and it was not identified that the medicine had been given or the GP had been contacted. This meant that it was not possible to identify that people's health needs were being fully supported.

Relatives felt confident that permanent staff could meet people's needs. One relative said, "The staff who work regularly with [person's name] are very, very good. If people don't deal with [person's name] properly he can be challenging. Staff who we spoke with told us that they received training to help them to understand their role. One staff member said, "I have done online training. I am booked to go on other

courses." Another staff member told us, "I have done my online learning. Some of the training is good. I had done training with my previous employer so I know about specific conditions." Training records showed that staff had received training that was required for their role. We saw that staff had completed courses specifically to support people at the service with their needs. These included training in epilepsy awareness and diabetes. However, only two members' of staff had completed training in the administration of buccal midazolam and one of these needed to refresh this training. Buccal Midazolam is a specialist medication that is used to treat prolonged epileptic seizures. Where someone is prescribed this medication staff must be appropriately trained to administer it. This meant that most staff were not able to administer this medicine if it was required and an ambulance would need to be called in the case of a prolonged seizure.

People were supported by staff who received some guidance and support in their role. There were processes in place to supervise all staff to ensure they were meeting the requirements of their role. However, these did not always appear to be taking place. Supervisions are meetings with a line manager which offer support, assurance and learning to help staff to develop in their role. Staff told us that they had not had regular supervision meetings but felt that they could talk to their manager. One staff member said, "I was due to have supervision today. I can talk to [registered manager]. They would listen." Another staff member told us, "I have not had supervision yet. I can talk to the managers though. They are approachable." The team leader told us that they had identified that staff were due to have supervision meetings and was in the process of arranging this. They told us that staff were supported by the team leader, the senior and the registered manager while on shift to make sure that they knew what was expected of them.

New staff were supported through an induction into their role. Staff described how they had been introduced to the people who used the service and said they had been given time to complete training, read care plans and policies and procedures. They also said that they had shadowed more experienced staff before working alone with people. One staff member said, "On my first shift I was an extra member of staff." The team leader told us that staff had two weeks of induction including time spend shadowing more experienced staff. Records we saw confirmed that this had taken place. We saw that the staff completed a workbook that included the Care Certificate. The Care Certificate was introduced in April 2015 and is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker.

People had access to a choice of meals, snacks and drinks. Relatives told us that people appeared to enjoy the food that they ate. One relative said, "From what I see on a Sunday they are always cooking a nice meal." Another relative commented, "They give [person's name] plenty of food." Staff told us that people chose their meals each day. One staff member said, "It would be good if there were meal plans for people based on what they like." They explained that food was prepared that people liked but there was not a plan in place to make sure that there was variety throughout the week. Staff told us that one person followed a gluten free diet and that they checked to make sure that the food that was provided was suitable for this. One staff member said, "There were some sausages that we got – you would think these were gluten free but I checked the ingredients and they were not suitable so I made [person's name] something else." Throughout the day people had access to the kitchen and could request a drink or food and staff made this for them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS had been requested for people who may have been at risk of being deprived of their liberty. The registered manager showed an understanding of DoLS which was evidenced through the appropriately submitted applications to the local authority.

A relative told us that they felt that their relative was involved in making their own choices. They said, "I believe [person's name] chooses what they want when they put out breakfast." We found that guidance was included in care plans about how to support people to be able to make decisions. For example, times of the day when they would be most receptive to information, formats to provide information in to help people understand and how to offer people choices in ways that were easier for them. Staff knew about this and could explain to us how to involve people in making their choices where they could do this. One staff member said, "I offer [person's name] two items so that they can pick one of them." Another staff member said, "[Person's name] will make it clear if they don't want to do something. I give them choices. If they don't want any of these I will offer something else."

Staff told us that they asked people for consent before undertaking any support. One staff member said, "I ask [person's name] if they want a bath, or to do an activity. They will let us know." Staff were able to demonstrate that they had an understanding of the MCA and DoLS and that they worked in line with the principles of this. This involved supporting people to make their own decisions and respecting their wishes. One staff member told us, "It is about encouraging people but we have to respect if they don't want to do something." Another staff member said, "Everyone has a DoLS. Someone came out last week to assess [person's name]. It is about if they can make choices." We saw that staff asked people if they wanted help before supporting them throughout our visit.

Good

Is the service caring?

Our findings

Peoples' relatives were generally positive about the support that was provided and the caring nature of regular staff. One relative said, "There are some super staff." Another relative commented, "Some staff are very much caring and kind. But then there are others. One staff member is very good at their job but doesn't have empathy." One relative said, "[person's name] has a good life." A health professional told us, "The interactions between staff and [person's name] are excellent. [Staff names] are brilliant members of staff." Staff we spoke with demonstrated their commitment to the people who used the service. One staff member said, "I come here for the people who live here. I enjoy working with them." Another staff member commented, "I enjoy working here. It is rewarding."

Throughout the day of our inspection visit, we observed that staff interacted with people in a warm and kind manner and took time to talk to people before proceeding with their tasks. They enhanced their verbal communication with touch and altering the tone of their voice appropriately.

People were supported in a respectful manner. A relative told us, "Dignity and respect. Oh yes everything there is fine." We saw that staff spent time with people throughout the day and talked to them about being involved in tasks. Staff told us how they promoted people's dignity. This included making sure people were covered during personal care and knocking on the door before entering a person's room.

People were involved in making decisions about their care. A relative told us, "I know exactly what [person's name] likes. I believe that he has choice about what he wants." This included decisions about meals, going out, and attending activities. Staff explained that they offered people choices about their care. One staff member said, "[Person's name] will tell us if they don't want to do something. It is up to them." We saw throughout our visit that people were asked if they wanted support with things such as using the toilet or what they wanted to eat.

People's preferences and wishes were taken into account in how their care was delivered. For example routines that they wanted to follow were detailed within care plans. Staff knew this information and used it to make sure people were following routines that were important to them. Information had been gathered about people's personal histories, which enabled staff to have an understanding of people's backgrounds and what was important to them.

People had the support that they required to be as independent as possible. People were encouraged to maintain the skills that they already had and to complete tasks they could do themselves. For example, people were encouraged to make their own bed, and help with washing their clothes. Staff told us how they involved people in these tasks to help them to develop and maintain their skills.

Staff were knowledgeable about the people they supported. They could tell us about people's preferences, likes and dislikes. One staff member explained the needs of one person. They told us, "[Person's name] likes orange to drink. That is their favourite." Another staff member explained the activities that people enjoyed. We saw that this information was recorded in people's care plans. This meant that staff had access to

information about what was important to the person and could use this to provide support to people based on what they liked and preferred.

People's visitors were made welcome and were free to see them as they wished. One relative told us, "I have started to come in more unannounced." Another relative said, "I visit each week. Staff tell us what [person's name] has been doing." One relative commented, "I can visit when I liked. They say feel free to drop in." The team leader told us that people's relatives visited frequently and this was encouraged as it was important to each person that they saw their family as much as they wanted to.

People's sensitive information was kept secure to protect their right to privacy. The provider had made available to staff a policy on confidentiality that they were able to describe. We also saw staff following this. For example, we saw that people's care records were stored privately when not in use. We also heard staff talk about people's care requirements in private and away from those that should not hear the information. This meant that people could be confident that their private information was handled safely.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported by staff who knew them well. One relative said, "My concerns are due to the huge turnover of staff. It is hard to know who is who and [person's name] really needs continuity." Another relative told us, "They don't seem to think about how people feel when staff move around suddenly." One relative commented, "I don't want any big changes. I just want to get more stable staff and ask why are they leaving." The team leader told us that each person required one to one support. They told us that there had been some changes in the staff team and that new staff were being recruited. The team leader said that where agency staff were used these were regular agency staff to increase consistency. People's care plans included information that guided staff on the activities and level of support people required. We saw that people's needs had been assessed and care plans had been put in place for staff to follow to ensure that their needs were met. Care plans contained information about people's preferences and usual routines. This included information about what was important to each person, their health and details of their life history. This enabled staff to provide support in a way that met people's individual needs and preferences.

People were offered activities. A relative told us, "The staff will tell us that [person's name] has been out to the zoo or the cinema." On the day of our visit one person had gone to a day centre. The other people went on a short walk to a local park. They spent most of their time playing with sensory equipment in the lounge with staff support. We saw that people had activity timetables in their care plans. However these were not followed. Staff could explain to us what activities people enjoyed doing and told us that people did not follow an activity plan. One staff member said, "They don't have a rigid routine. [Person's name] plays with sensory equipment for hours. [Person's name] is not really into anything." Staff told us that people did take part in activities. One staff member said, "What people do depends on the weather and their mood. They can go to town or to the pub for meals. They don't have a rigid routine. Another staff member told us, "There is always something. Even if it is only a hand massage." We looked at the daily records for one person and noted that they did take part in an activity they enjoyed, However this took place every day and there were very limited times when other activities were recorded.

People's care and support needs were assessed prior to anyone moving into the service. This was to make sure that the staff team could meet people's needs appropriately. Records we saw confirmed that this had taken place. We found that people's care plans were very focused on them as individuals. This included information about how the person had been involved with developing their plan. For example, we read that one person had been observed during their personal care routine with staff they knew and liked to see how they wanted to be supported which was then included in the care plan. We saw that care plans identified what was a good morning and night for each person so there was guidance about how people preferred to be supported. Staff who worked regularly at the service were able to explain to us how people wanted to be supported. Other staff were less able to do this. One staff member said, "I don't really know about [person's name] you will need to speak with [staff member] as they work with them regularly. I have not read their care plan."

People and their relatives were not sure that they had participated in reviewing their care plans. A relative

told us, "They have been developing and updating the care plan. I'm not involved. We have never been asked about it." Another relative said, "If we come to the reviews we talk about [person's name]. If they have a meeting they let us know afterwards what they have decided." The team leader told us that each year a review was held that involved the person and their family if they wanted to be. Following this the care plan was updated. We saw records of these meetings that showed that reviews had been held. We found that care plans have been reviewed annually or when someone's needs had changed. This meant that care plans included up to date information about people's needs.

People were supported to develop their independence. One staff member told us, "[Person's name] will help to make their bed, and get their clothes from the laundry." We saw that care plans prompted staff to involve people to maintain and develop the skills that they had. For example, one care plan said, 'with encouragement [person's name] will help with drying and dressing.'

People's relatives told us that they would speak with staff or the registered manager if they were worried or had any concerns. However, they felt that this was not always easy as there had not been consistent leadership. One relative said, "I haven't made any complaints but I was getting close to doing it. I haven't had a line of communication with the management. [Registered Manager] is new." Other relatives told us that they had not needed to complain. There were procedures for making compliments and complaints about the service. These included a form called see something say something that were available for people, relatives and staff to raise any concerns that they had. The team leader told us that no complaints had been received.

Requires Improvement

Is the service well-led?

Our findings

People's relatives told us that they did not always received good communication from the provider or the management team at the service. One relative told us, "It has been terrible for communication. I'm not told about what is happening. There is a total lack of communication." Another relative said, "They don't seem to be doing anything like they did before. I used to have pictures when [person's name] went on holiday. The concerns I have are about a lack of information being passed on. We are in the dark a lot of the time." One relative commented, "I don't know about the changes and why they happen." However, another relative said, "If [person's name] has an accident or falls over they always ring us up to tell us."

Relatives explained that they felt that communication and staffing problems were impacted on by a lack of consistency in the management of the service. A relative said, "With several different managers changing we are not well informed." Another relative told us, "My concerns come back to the huge turnover of staff, particularly management staff. I have not got the name of any senior person but I have wanted to contact them. They seem to parachute managers in who go away again." Another relative commented, "[Registered manager] is new, very new. I have told her about my concerns." One relative said, "The service doesn't seem to deal with the problem. I don't know who is responsible there." At the time of our inspection the registered manager was on leave. We spoke with them following the inspection. They told us that they were working to develop relationships with the family members and improve communication. We found that there had been changes within the management at the service and for the senior managers since our last inspection. Staff told us that this had been difficult. One staff member said, "I got on with [area manager] and [registered manager]. Now they have changed again." Another staff member said, "The manager changes every six months." The registered manager had only been at the service since December 2016. Following the inspection they resigned from their position. The senior managers contacted us to tell us of this change and of a new management team being brought in to support the service.

People's relatives had been asked for their feedback on the service through the use of questionnaires. However, they felt that their feedback was not asked for in other ways and when it was provided they were not always listened to. One relative said, "The main problem is following things up. It is like they say, 'We listened to you', but things need to be done. They are listening but not doing." Another relative told us, "They don't get my thoughts of the service. Sometimes they send a tick sheet. When a senior comes like today they could talk to me. But there is none of that." One relative commented, "They have asked us questions. They send a survey about once a year." We saw that surveys had been sent out to people and their relatives in 2016. Only one was returned. This did provide positive feedback.

The provider monitored the quality of care at the service and aimed to improve this. Audits were carried out quarterly on all aspects of support in the service. This included checks on medicines, care plans and the premises. Following the audit an action plan had been developed to determine how to resolve any concerns that were found. The action plan was sent to us following the inspection. We saw that a number of the areas we found during our inspection had been identified as concerns. However, we also found that the audit and action plan had not identified all of the concerns we found. For example, the premises required a thorough clean and repairs. Although it had been identified that cleaning schedules were not followed regularly action

had not been identified to make sure the property was cleaned properly. Following our inspection we spoke with the chief operating officer. They did provide feedback on immediate actions that had been taken. These included a quote for a cleaning company to carry out a deep clean and immediate repairs on some equipment. This meant that the processes that were in place to monitor the quality of the service and drive improvements were not consistently identifying and addressing concerns.

Staff told us that they attended team meetings. Team meetings provided the staff team with guidance about their role. One staff member commented, "I have been to one team meeting. We discussed processes so that we know what to do." Staff gave mixed feedback about being able to approach their manager and feeling supported. One staff member said, "I can talk to [registered manager]. They will listen. Another staff member told us, "The place is lovely to work at but the management don't listen. I have raised things with [registered manager] and nothing has been done." We were not able to see minutes from the last team meeting. The team leader told us that the registered manager had discussed ways to improve the service and how things should be done. Staff confirmed this. We saw that one of the actions that had been identified was to hold more regular staff team meetings with a set agenda that included health and safety, safeguarding, the action plan and training.

We saw that the provider had made available to staff policies and procedures that detailed their responsibilities that staff were able to describe. These included reference to a whistleblowing procedure within the safeguarding procedure. A 'whistle-blower' is a staff member who exposes poor quality care or practice within an organisation. Staff members described what action they would take should they have concerns that we found to be in line with the provider's whistleblowing policy. One told us, "I know I can go to external bodies including CQC."

The registered manager was aware of their registration responsibilities. Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. The registered manager had informed us about incidents that had happened appropriately.