Care Management Group Limited

Care Management Group - Shardeloes

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?	Good
Is the service well-led?	Requires improvement

Overall summary

Shardeloes is a care home for up to nine adults with learning and physical disabilities. Some people were very independent and needed little support from staff, while others were essential wheelchair users, or were blind or partially sighted. At the time of our visit nine people lived here.

Care and support are provided on two levels. Communal areas include a large lounge and separate dining area.

The inspection took place on 16 October 2015 and was unannounced. At our previous inspection in November 2013 we had not identified any concerns at the home.

There was not a registered manager in post. They had left in July 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

The lack of good leadership after the departure of the registered manager had an impact across three of the five key areas we looked at. It affected the safety of the home, how effective the home was at meeting people's needs, and how well the home was led.

There was positive feedback about the home and caring nature of staff from people and their relatives. One person said, "The staff are nice, they will get me anything I want. There is nothing they could do better for me." A relative said, "I think my family member is leading a very good life here."

People were not always safe at Shardelos. The home had not been well maintained and was not always clean. Cleanliness needed to be improved around the home and hand washing facilities such as soap and hand towels were not always available to people, unless they asked. Lack of maintenance left items such as walls and furniture difficult to keep clean.

Adjustments to the environment to better suit the needs of individuals had not been assessed. At least two people were blind or partially sighted, but no reasonable adjustments had been made to the home. People had to rely on staff leading them around the home, rather than having adaptations that may help them to help themselves.

Where people did not have the capacity to understand or consent to a decision the provider had not followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had not been completed. People told us that staff did ask their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected. Staff's understanding of their roles and responsibilities within the DoLS was not effective.

The staff were kind and caring and generally treated people with dignity and respect, but areas for improvement were identified. Staff's practice around confidentiality needed to improve, for example talking about people in communal areas where others could hear. Some good interactions were seen, such as friendly banter with people, or staff taking the time to sit and play cards with people.

There were enough staff to meet the needs of the people. How staff are deployed to best support the people that live here could improve. There were a number of times during the day were staff were talking amongst themselves and people were left with no interaction apart from the television. The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home.

The training and induction processes for staff needed to improve. New staff had not received an effective induction in accordance with the provider's policy. Training around new approaches to support had not been given to staff, for example new guidance on preventing and managing choking had been issued by the local authority but staff were unaware of this. Some staff had not completed mandatory training, such as moving and handling. Whilst they knew they were not able to support people until they had done the training, it did impact on the effectiveness of the staff in being able to support people.

Quality assurance processes had not been effective at improving the home for the people who live here, or supporting staff in the absence of a manager. Regular audits were completed around the home by staff and visiting senior managers. Items identified as requiring action had not always been completed within the timescales set by the provider. Some care records were not completed fully, or had conflicting information. These had not been identified by the provider's internal checks. Accident and incident records were kept, and they were analysed and used to improve the care provided to people.

People and staff did have the opportunity to be involved in how the home was managed. People told us that they had regular residents meetings where they could talk about the home and their care. Staff had meetings with their manager, but these had stopped when the registered manager left. Improvements identified at these meetings had not always been implemented by the

Summary of findings

provider. The provider had also not always feedback to people why these suggestions had not been done, so people were left waiting, not knowing if anyone had listened to them.

Care plans were based around the individual preferences of people as well as their medical needs. They gave a good level of detail for staff to reference if they needed to know what support was required. However important information about people's support needs was not always clear in the files, so some staff had been unaware of those needs. People told us they were involved in the review and generation of these plans. People received the care and support as detailed in their care plans.

People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them.

People received their medicines when they needed them. Staff managed medicines in a safe way and were trained in the safe administration of medicines. One area for improvement was identified. This was around staff monitoring the temperature of the cupboard where medicines were stored to ensure it was maintained at a temperature that would not affect the medicines.

People had access to activities that met their needs. They had access to the local community and could attend a variety of activities and clubs. More individualised activity plans were being developed with people by the staff, so that people's dreams and new interests could be supported.

People had enough to eat and drink, and received support from staff where a need had been identified. Specialist diets to meet medical, religious or cultural needs were available should they be required. People were involved in what they ate, and told us they had a good variety and choice.

People knew how to make a complaint. Documents recorded that complaints had been responded to in accordance with the provider's policy.

We identified two breaches of the regulations. You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement

The service was not always safe.

The provider had identified some risks to people's health and safety and put guidelines for staff in place to minimise the risk. However poor maintenance of the premises and cleanliness issues meant there was a risk to people from infections.

There were enough staff to meet the needs of the people. However the staff deployment to support people could improve.

Staff understood their responsibilities around protecting people from harm. They were clear on their roles and responsibilities should they suspect abuse had taken place.

People felt safe living at the home. Appropriate checks were completed to ensure staff were safe to work at the home.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Is the service effective?

Requires improvement

The service was not always effective

People's rights under the Mental Capacity Act were not met. Assessments of people's capacity to understand important decisions had not been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

Staff said they felt supported by the manager, and had access to training to enable them to support the people that live here. However some training was out of date and new staff had not received an induction in line with the provider's policy. This meant that staff's knowledge of some subjects required improvement,

People had enough to eat and drink and had specialist diets where a need had been identified.

Is the service caring?

Good

The service was caring.

People told us the staff were caring and friendly. We saw some good interactions by staff with people. Some minor issues with staff's understanding of confidentiality and respect were raised with the manager.

Staff knew the people they cared for as individuals; however some staff had been unaware of particular support needs for one person as the information in care records was hard to find.

Summary of findings

Is the service responsive?

Good 

The service was responsive to the needs of people.

Care plans were person centred and gave detail about the support needs of people. People's involvement in their care planning was clear.

People had access to activities; these were being improved to be more individualised and meet the interests and need of people.

People knew how to make a complaint. There was a clear complaints procedure in place. Complaints had been dealt with in line with the provider's policy.

Is the service well-led?

Requires improvement 

The service was not always well-led.

The provider had not given appropriate support when the registered manager had left the home. Quality assurance checks had been completed, but improvement actions were not always completed within the timescales set by the provider. Care records were not always completed, and records were missing or gave conflicting information. The new manager had identified many of the concerns we raised and was working through an action plan to improve the service.

People and staff were involved in improving the service. Feedback was sought from people via an annual survey and house meetings, but little information was available to show how this had been used to improve the home.

People were complimentary about the friendliness of the staff. Staff felt supported and able to discuss any issues with the manager.

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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 16 October 2015 and was unannounced. The inspection team consisted of two inspectors, both of whom had experience in learning and physical disability care.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This 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. This was because we were carrying out this inspection in relation to some concerns we had received about the home.

During our inspection we spoke with five people, one relative, and five staff which included the manager and area manager. We also spoke to an advocate who supported a person who lived at the home. We observed how staff cared for people, and worked together. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also reviewed care and other records within the home. These included three care plans and associated records, seven medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspection in September 2013 we had not identified any concerns at the home.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe living at Shardelos. A relative said, "The most important thing is he is safe. I can sleep in my bed at night."

There were sufficient staffing levels to keep people safe and support the health and welfare needs of people living at the home. One person said, "There are plenty of staff here." However it is recommended the provider review the deployment and duties of staff to ensure the maximum support for people. People were left on their own with nothing to do, staff often congregated together in the kitchen. They could have been more proactive with the people living in the home.

Planning to ensure there were enough staff to meet people's needs was safe. Peoples care needs had been assessed and a staffing level to meet those needs had been set by the provider. Levels of staff seen during the day of our inspection matched with the level identified by the provider as being required to meet people's needs. Staffing records also confirmed that the appropriate number of staff had been in the home to support people for the previous month.

People were not completely safe as the premises were not always clean or well maintained. One bedroom upstairs had a carpet that was stained. The bannister on the stairs had paint which was worn and the stairwell walls were stained and dirty. The washing machine was covered in caked washing powder and the kitchen floor around the base of the units was dirty. There was a strong urine smell in the upstairs bathroom and the bath had lime scale around the overflow outlet. The paintwork was chipped and the floor was dirty around the base of the bath. All these concerns would make it hard to keep the home clear as they presented rough surfaces that can harbour germs.

The bedroom used by staff, which people could access, had a broken window restrictor so there was a risk of falling. Windows were old and let in drafts, making rooms such as bathrooms cold. Furniture was worn and stained in communal areas. Repairs around the home had only been partially completed, for example a frame around a door had bare wood, which would make it harder to keep clean.

People did not always have access to hand washing facilities. The bathrooms upstairs and downstairs had no soap, no hand towels and there were used clinical gloves in an open bin. Staff explained this was due to one person who put these things down the toilet. They were always having to have the toilets unblocked. They said there was soap in the downstairs toilet, however when we checked this was not the case. Staff said that if people were seen to be going to the toilet they would provide them with handtowels and soap. There was a risk that people could use the toilets and then not be able to wash their hands, increasing the risk of spreading infection around the home.

Due to the risk to people from an unclean, poorly maintained environment, it is recommended the provider review the maintenance, cleanliness and infection control management processes at the home and take the necessary actions to minimise the risk of infection.

The storage of medicines could improve. People had medicines stored in their bedrooms; however the temperature they were stored at was not consistently recorded. This could mean medicines were stored outside their temperature range which may affect their effectiveness.

People's medicines were managed and given safely. Staff that administered medicines to people received appropriate training, which was regularly updated. Their competency to give medicine safely was reviewed by a senior staff member to ensure they followed best practice.

The ordering, storage, recording and disposal of medicines was safe. There were no gaps in the medicine administration records (MARs). So it was clear when people had been given their medicines. People had their medicines when they needed them.

The premises had not been fully adapted to suit the needs of the people that lived here. People who were blind or partially sighted lived in an environment that had not been adapted to meet their needs. Walls and doors were all the same colour, so would be difficult for them to distinguish between the two; hallways were not always well lit making it harder for them to see; there were no handrails on the walls for them to be able to guide themselves around the home. We recommend that the provider seeks and follows best practice guidance to ensure people are provided with a home environment that meets their specific needs.

Requires improvement

Is the service safe?

People were kept safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the keyworker to look for patterns that may suggest a person's support needs had changed.

People were protected from the risk of abuse. Staff understood their responsibilities in relation to safeguarding people. They were able to identify the correct safeguarding procedures should they suspect abuse, and that a referral to an agency, such as the local Adult Services Safeguarding Team should be made. Information was also made availingly to people and visitors about abuse. Pictorial safeguarding information was on the noticeboard in the lounge area. This was easy to access and understand should people wish to know what to do if they thought abuse was taking place.

The risk to people from their health and support needs had been assessed to help keep them safe. Assessments had been carried out in areas such as nutrition and hydration, supporting independence (such as kitchen safety) and mobility support needs. Measures had been put in place to reduce these risks, such as monitoring people's weight and food and fluid intake where people were at risk from malnutrition. Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs. However the risks were not always individualised to the person. No assessment of risk had been completed when people went on holiday over the summer, nor had the risk from people self-medicating been assessed.

People were kept safe from environmental hazards. Assessments had been completed to identify and manage any risks of harm to people around the home. Areas assessed included fire safety, and health and safety risks (such as trip hazards around the home). Staff worked within the guidelines set out in these assessments. Equipment used to support people was regularly checked to make sure it was safe to use. Items such as fire safety equipment were regularly checked. The home's design and maintenance also reduced the risk of harm to people. Flooring was in good condition to reduce the risk of trips and falls, although, as we have reported lighting could be improved to further reduce the risks.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, were clearly displayed around the home. People's individual support needs in the event of an emergency had been identified and recorded by staff in personal emergency evacuation plans (PEEPs). These gave clear instructions on what staff were required to do to ensure people were kept safe. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We noted that there was one staff file that had no picture, nor a record of any references. The other files we looked at did not have these omissions. The missing information was added to the file by the manager, and a copy sent to the CQC immediately after our inspection visit, so we were assured that people had not been put at risk.

Requires improvement

Is the service effective?

Our findings

People told us they home was effective at keeping them healthy and meeting their needs. One person said, "I get to see the doctor and optician when I want." A relative said, "From a health point of view the staff are looking after him very well." Despite people and their relatives positive views we found two breaches of the regulations that require action to ensure people always received effective care.

The provider had not complied with the requirements of the Mental Capacity Act 2005 (MCA). Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were not always effectively followed. Assessments of people's capacity had not been completed correctly as they were not based on a particular decision that the person had to make. Instead a statement was made of the person's medical condition.

Staff did not have a good understanding of the Mental Capacity Act (2005) including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. They could not describe the purpose of the Act to us and its potential impact on the people they were caring for. One staff told us they had received no training on these areas from the provider, so had to look it up on the internet.

Because the requirements of the MCA were not effectively fulfilled, this was a **breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care services are looked after in a way that does not inappropriately restrict their freedom. Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

The registered manager had sought the written consent of people or their representatives. These were in areas such as photography for identification purposes and sharing personal information with outside agencies such as GP's and other healthcare professionals. During the inspection staff were heard to ask people for their permission before they carried out tasks, such as supporting them to get out of chairs.

People and relatives told us that care staff had sufficient knowledge and skills to enable them to care for people. Staff had some training to undertake their roles and responsibilities to care and support people. The training was not as effective as it should be. The induction process for new staff was not robust enough to ensure they had the skills to support people effectively. One new member of staff had received very little in the way of a structured induction. It had mainly consisted of being shown around the home and reading peoples care plans. Their training and induction plan had not been completed in the timescale detailed in the provider's induction policy.

Key areas of staff training were also not addressed, or out of date. Staff had not received up to date training on how to support someone who may be choking. They were also unaware of the current guidelines for this issued by the Local Authority due to a number of deaths in the county. Two people required a fork mashable diet so were at risk of choking. Some staff had also not received training in supporting people with moving and handling. They told us they were not expected to support people in this way until they had completed the training, but it limited the support people could receive.

As training was not up to date in key areas that could affect the care and safety of people there was a breach in **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Specific training around the needs of the people who lived at the home had been given to staff. For example staff had received training on supporting people with autism and had an understanding of how to put this into practice.

People had enough to eat and drink to keep them healthy and were happy with the quality, quantity and choice of food and drinks available to them. People were involved in the menu planning and shopping and regularly had their favourite meals. People told us they were involved in choosing the menu each Sunday as they sat down and made suggestions of what they would like. The weekly

Requires improvement

Is the service effective?

menus had individual days' food chosen by different people. There was a good range of food, as well as sandwiches and snacks. If people did not like what was on the menus an alternative was always provided.

People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy. A relative told us about their family member who had had a weight problem. Staff had reviewed his diet with him and his relative said, "he was looking so much better."

Staff had not been effectively supported. Staff told us that they felt supported in their work, however due to the departure of the registered manager, had not been fully supported for the last two months. Staff had regular supervisions (individual one to one meetings with their line manager) and appraisals, but hadn't had anything in the last two months since the departure of the manager. The new manager had a plan to begin the process again by the end of October 2015. The provider's policy stated supervisions should be carried out every month to six weeks. The provider had not ensured staff were appropriately supervised in line with their policy when the registered manager left. The new manager had sent information to the CQC after the inspection, to confirm that supervisions were now taking place with staff.

People received support to keep them healthy. People said they were able to see the doctor whenever they needed to, or go to hospital if necessary. People had access to health care professionals suited to their support needs. Care records demonstrated that where people's needs had changed appropriate support was sought. People also had access to speech and language therapist (SALT) for assessment of their speech or swallowing, and occupational therapists to aid with their mobility needs. Advocacy services had also been used to support people who may not have been able to fully understand the help and options available to them. Where a person had a leg ulcer, the care and support provided by the staff had been effective as the ulcer had healed.

Good

Is the service caring?

Our findings

We had positive feedback from people about the caring nature of the staff. People told us that they had good relationships with staff and that staff were kind and caring. One person said, "I like it at the home, the staff are nice." A relative said, "Staff are very friendly and always smiling."

There were some areas around confidentiality, and respect that could be improved. In the morning one staff member came into the home they did not acknowledge the four people in the lounge or say hello to the person they were key worker for. People's confidentiality was not always respected by staff. A staff member was overhead talking to a relative about a recent incident between two people. While this was positive in that they were passing on information to keep the relative informed, this was done in the hallway were everybody in the lounge and dining area could hear.

Staff were generally knowledgeable about people and their past histories. However staff told us that until recently they had not been aware of some people's histories, which required special support. For example one person had a particular behaviour that staff needed to be aware of while supporting the person in the community. They had only been made aware when a recent review of the care plan brought the matter to their attention.

Staff were able to communicate effectively with people. People said that staff understood them and they were able to understand what staff said to them. Staff were undertaking tasks all morning, so only spoke occasionally to people. This was often done by calling from another room, rather than going to the person to interact with them. Staff rarely spent time in meaningful conversation with people during our inspection. Staff did not often sit beside people and talk with them. However we also saw some very positive interactions. One member of staff played cards with a person. This went on for 25 minutes. The staff member congratulated the person at the end of the game saying, "Well done, that was a good game."

People looked well cared for, with clean clothes, and tidy hair. The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. People were seen to be happy sitting together and talking amongst themselves. Staff spoke with people at a pace and in a manner which was appropriate to their levels of understanding. An advocate said, "The staff are caring and know what to do." Some good examples of supporting people to move were seen with staff clearly explaining to people what they were doing and why.

People's dignity and privacy were respected by staff. Staff explained how they did such as ensuring people were covered when they were provided personal care and curtains and doors were closed. Staff said if people were walking between rooms they would ensure they had clothes on. They added that sometimes people wanted their own space and they would support them to go to their rooms and ask if they wished the door left open or not.

Staff had an understanding of how to promote people's independence. People told us about jobs they did around the home such as peeling potatoes, using the dishwasher and other tasks in the kitchen. People were also involved doing their own laundry. A relative said, "My family member helps around the home, this is stimulating for him."

People were given information about their care and support in a manner they could understand. However during our inspection the interaction between staff and people was generally limited to task based activities, with little meaningful social interaction. Where people may need support in making decisions advocacy services had been used. An advocate told us how they had been involved to help a person with a decision about their support needs. There was a positive outcome for the person as their support was changed to reflect their wishes.

People's rooms were personalised with family photographs, ornaments and furniture. This made the room individual to the person that lived there. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs and people had access to services so they could practice their faith.

Good

Is the service responsive?

Our findings

People were positive about how the service met their needs. A relative said, "I think my family member is leading a very good life here."

People's care and treatment was planned and delivered to reflect their individual care plan. The records were legible and up to date. People were involved in their care and support planning. People confirmed that they had always been involved in completing the care plans. One person said, "They (staff) talk me through my care plan." Another person told us about how they completed their own review with their keyworker. This looked at what he had achieved over the month and how he had progressed towards his goals. These were seen in the persons care records. Where people could not be involved themselves relatives were involved. People had also signed their care plans to show they had been involved. Care plans were regularly updated in line with people's changing needs, such as when a person's goals had been achieved. There was sufficient information in care plans about people's health needs to show these were being met.

People's choices and preferences were also documented and those needs were seen to be met. There was detailed information concerning people's likes and dislikes and the delivery of care. Care plans were comprehensive and were person-centred in varying degrees. However a lot of repetitive information was found which was at times contradictory, for example peoples religious beliefs. Important information about peoples support needs was not necessarily at the front of the notes and therefore not immediately available for staff. One staff member was unaware of a person's behavioural support needs when out the community because of this.

People had access to a range of activities such as day centres, volunteering and practicing their religious faith. A relative told us, "There's stuff going on all the time – it's about a near perfect existence as you could get – don't know how my family member has time to do it all." Activities were not always available that reflected people's individual interests. One person told us how staff talked with him about the activities he'd like to do. However a plan to achieve these had not been completed. For example a trip up to London to visit the Shard, or to find out about access to local hobbies and sport that had been tried and enjoyed whilst people had been on holiday.

Activities advertised in the home did not always match with what was actually given. There was an easy to read timetable of activities in the lounge area, but the activities on offer did not take place on the day of our inspection. People were seen to have long periods of time with no stimulation, which resulted in some of them falling asleep in the lounge area. The activities board showed some people doing cleaning, laundry and watching TV all week, however no outside activities were shown. People were able to access the community, for example to go out shopping and visit relatives.

People's needs had been assessed before they moved into the service to ensure that their needs could be met. They contained detailed information about people's care needs, for example, in the management of the risks associated with people's mobility or dietary needs. The care plans contained detailed information about the delivery of care that the staff would need to provide.

People's independence was promoted by staff. People told us about how they did their own laundry. Peoples achievements around independence where celebrated with them. Awards were given to people when they had succeeded in a goal. Examples included people managing their own medicines and writing their own report for care reviews.

People were supported by staff that listened to and responded to complaints. People and relatives knew how to raise a concern or make a complaint. One person said, "I would write it (the complaint) down, but I'm happy here and haven't needed to complain." People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed.

There was a complaints policy in place. This was prominently displayed in the home. It was also in a format that most people who live here would be able to understand. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission. A relative confirmed they knew how to make a complaint, but have never felt the need to.

Complaints had been dealt with in line with the provider's policy. Two complaints had been recorded in 2015. One had been resolved and the other was going through the

Good

Is the service responsive?

organisation's complaints procedure. Actions taken included a meeting with the complainant and an action plan had been developed following the meeting to address the concern raised. The actions on the plan were being progressed at the time of our inspection to address the complaint.

Requires improvement

Is the service well-led?

Our findings

There was a positive and friendly culture within the home between the people that lived here, the staff and the manager. A relative said, "The culture in the home is good. It is all very friendly, staff are focussed on what they were doing and there is never any (negative) atmosphere." Despite people and relatives positive feedback we found some improvements were needed to ensure people lived in a home that was always well led.

The provider had not demonstrated good management and leadership of the home after the departure of the registered manager. Staff told us that although the area manager visited they had been without a permanent manager for two months. Staff meetings had been held each month prior to the departure of the registered manager. These did not take place between July and September 2015 when the staff may have needed support and guidance. Staff told us this had been unsettling for them as well as the people who lived at the home. Staff said that this did have an impact on one person because they were on holiday when the registered manager left and came back to find a different manager. No one had thought to tell them, and explain what had happened. The staff said the person's mood had been very up and down since.

The lack of a registered manager also affected the effectiveness of the quality checks completed at the home, as they had taken place, but their results were not always actioned. For example an infection prevention audit completed in July 2015 identified a need to replace the dustbin in the kitchen to a foot operated one. This would reduce the risk of people and staff spreading infection as they would not need to touch the bin with their hands to open it. The new bin was not in place at the time of our inspection. The action was recorded as being due to be completed by August 2015. Another example was where an identified trip hazard in the garden had not been addressed by the provider.

Record keeping was not consistent. Gaps were seen in care plans, and medicine administration records. A manager was in place at the time of our inspection. They had already identified the majority of the concerns we raised and had an action plan in place to tackle them. We could see that actions had been completed in the timescales recorded in this plan. This showed the manager was working towards improving the home to better meet the needs of the people that lived here, and to support the staff.

Due to the issues experienced by people and staff after the departure of the registered manager it is recommended that the provider reviews how, people using and staff working in their homes are supported during the periods when a permanent manager is not present.

Senior managers were involved in checking the quality of the service at the home. This was intended to give them a direct understanding of what people felt and what was happening within the home. People were able to tell us the names of these managers, and that they visited and spoke to them about their experiences at the home. The values of the home were understood by staff, and they were seen to be working in line with them, for example promoting peoples independence.

People and relatives were included in how the service was managed. However feedback was not always acted on. During house meetings people had asked for new furniture and other changes around the home, but none of these had been done. Nor had an explanation been given to them.

Staff were also involved in how the service was run. They were invited to staff meetings held by the new manager. The staff discussed any issues or updates that might have been received to improve care practice. However they felt less supported by the provider. Two staff said they had regular staff meetings and also felt they could speak up in these, but they didn't feel they had a voice because their ideas had not been listened or responded to by Care Management Group.

The manager had ensured that various groups of people were consulted for feedback to see if the service met people's needs. This was done annually by the use of a questionnaire. A relative said, "I receive a form each year for my views on the home." The results of these surveys were analysed by the provider and then fed back to the staff to highlight areas of good practice, or where things needed to improve.

Staff felt supported with the new manager and able to raise any concerns with them. One staff member said, "I couldn't work at a better service." Staff confirmed to us the manager operated an 'open door' policy and that they felt able to

Requires improvement

Is the service well-led?

share any concerns they may have in confidence. Information for staff and others on whistle blowing was on display in the home. Staff understood what whistle blowing was and that this needed to be reported.

The home was currently without a registered manager. A new manager was in post and said their application to CQC would be sent in as soon as possible. The new manager provided good leadership for the home and supported the staff team in providing care and support when needed. The manager was visible around the home on the day of our inspection. They were available to people and relatives if they wished to speak to them. It also gave the opportunity to observe the care and support that staff gave to people, to ensure it was of a good standard. The manager had a good rapport with the people that lived here and knew them as individuals.

The manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the manager in line with the regulations. This meant we could check that appropriate action had been taken.

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 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider had not acted in accordance with the Mental Capacity Act 2005 where people may lack capacity to give consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider had not ensured that persons providing care to service users had the qualifications, competence, skills and experience to do so safely.