Mermaid Care Limited

White Pearl Residential Care

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**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 9 and 10 October 2018. This is the first inspection since the provider registered with the Commission in October 2017.

White Pearl Residential Care is registered to provide accommodation and residential care for up to 18 people with a variety of mental health needs, including conditions such as paranoid schizophrenia, bi-polar disorder and substance misuse. At the time of the inspection, 14 people were living at the home. Communal areas include a large sitting room with dining area and access to extensive rear gardens. There is also a quiet lounge and a designated smoking area. All rooms are of single occupancy and have en-suite facilities. A lift is available for people if required. White Pearl Residential Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

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

Some aspects of medicines were not managed safely. Gaps in the completion of some Medication Administration Records (MAR) meant that one person may not have received their medicines on two occasions as prescribed. MAR had not always been completed accurately by staff or in line with National Institute for Clinical Excellence (NICE) guidelines. The recording of one medicine had not been done as legally required. Medicines were not audited to check that medicine administration worked effectively and any issues could be identified and addressed.

Staff said they completed training in safeguarding adults at risk, but some staff did not have a full understanding of the subject or how to keep people safe. We have made a recommendation about safeguarding training for staff. Staff had completed training in a number of areas, but there was no formal training plan to confirm that staff had completed the training they required. Staff were encouraged to study for vocational qualifications in health and social care.

Systems or processes had not been established to assess or monitor the service provided to people. Risk assessments were lacking in some areas, but there was no evidence to show this impacted on people's safety. Auditing systems had not been set up to monitor or measure the quality of care or to drive improvement. People's feedback about the service had not been requested or documented formally.

There were sufficient numbers of staff on duty to meet people's needs. Checks were made on new staff to ensure they were of good character and safe to work with people.

People were supported to have sufficient to eat and drink and had a choice of menu. They had access to a range of healthcare professionals and services. People's rooms were personalised and they had access to outdoor space. The registered manager worked with a variety of organisations to deliver effective care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were looked after by kind and caring staff who knew them well. Staff respected people's privacy and supported them to be as independent as possible. People were encouraged to be involved in all aspects of their care.

Information within care plans was not detailed, but staff knew people well and how to support them. The deputy manager had plans to improve records in relation to care plans, risk assessments and to set up auditing systems. People pursued their own interests in the community and were free to go out during the day.

Formal supervision meetings did not occur, but the registered manager worked alongside staff and observed their working practice. Staff felt supported by the managers and enjoyed working at the service. The registered manager had a clear vision about the service and how to support people to recover and move back into the community. People said staff were always available and had time to spend with them.

Due to the shortfalls we found in the monitoring of the quality of the service and in the management of medicines we found two breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

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

Some aspects of the service were not safe.

Some Medication Administration Records (MAR) had not been completed accurately or in line with good practice.

People's risks in relation to their safety had not been fully assessed. Some staff did not have a good understanding of safeguarding and training on this topic was not effective.

Premises were managed safely and servicing of installations and equipment were satisfactory.

Staffing levels were sufficient to meet people's needs. Checks were made on new staff before they commenced employment.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

There was no training plan or training records. to show whether or when staff had completed training. Staff felt supported by managers but staff did not have formal supervisions.

People's needs were holistically assessed. People had access to a range of healthcare professionals and services and were supported to live healthy lives.

People had sufficient to eat and drink and a choice of food. Rooms were personalised and people had access to smoking areas and outside space.

People were not unlawfully deprived of their liberty. The requirements under the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards had been met.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them well. Positive relationships had been developed.

People were involved in decisions relating to their care and were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. People were encouraged to be as independent as possible.

Activities were not organised as people could pursue their own interests independently in the community.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Systems or processes had not been established to measure or monitor the quality of care or service overall. People's feedback about the service had not been formally sought.

Staff enjoyed working at the service. Staff had time to spend with people.

The service worked in partnership with other agencies and professionals.

White Pearl Residential Care

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.

The inspection took place on 9 and 10 October 2018 and was unannounced. The inspection was undertaken by one inspector.

Prior to the inspection, we reviewed the information we held about the home. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. On this occasion, we did not send a request to the provider to complete a Provider Information Return. A Provider Information Return is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. White Pearl Residential Care is a relatively new service and registered with the Commission in October 2017. This is the first inspection.

During the inspection, we spoke with four people who lived at the home. People were asked if they would like the opportunity to talk with the inspector at the time of the inspection and the majority chose not to do so. For many people, this would have caused them undue anxiety or stress. However, we spent time observing people in communal areas around the home. We spoke with the registered manager, deputy manager and three care staff. We spent time observing the care and support people received and also observed a member of staff administering medicines to people.

We reviewed a range of records about people's care and how the home was managed. These included four care records, daily notes, risk assessments and medicines records. We also looked at staffing levels and recruitment, policies and procedures and other records relating to the management of the home.

Some records were not available to us at the time of the inspection, so we asked the registered manager to

send copies of these to us. These included servicing records relating to premises management, staff recruitment documents relating to four staff, staff training and governance.

Requires Improvement

Is the service safe?

Our findings

This is the first inspection so this key question has not previously been rated.

Medicines were not always managed safely. We looked at the Medication Administration Records (MAR) for every person living at the home who was prescribed medicines. The majority of MARs had been completed accurately by staff to show that people had received their medicines as required. Some MARs had not been completed accurately by staff. On each printed MAR, a letter code defined the administration of the medicine. For example, 'A' meant the person had refused their medicine, 'B' that a medicine had resulted in nausea or vomiting and 'C' that they were in hospital. The code 'F' equated to 'Other' where staff needed to define what had happened when administering a medicine. In one person's MAR, a code of 'N/R' had been used, presumably meaning that this medicine was 'not required'. However, this meant the MAR had not been completed in line with guidelines and the meaning could have been misinterpreted. We also found gaps in another MAR, where staff had not signed to confirm whether one person had received a particular medicine. A staff member had used '/' in a few instances and it was not clear what this meant. We could not establish whether this person had received their medicine to treat their anxiety on two separate occasions and they were unable to tell us. This could have had a negative impact on the person and on their wellbeing.

We looked at the storage of medicines that require to be stored in line with the requirements of The Misuse of Drugs Regulations 2001. A drug we checked needed special storage and recording requirements. We observed the drug had been locked in a separate cabinet within the medicines room but the drug had not been recorded or signed for accurately in an appropriate book as defined by the Regulations which should be a bound, page numbered register. We found a record of this medicine had been written by staff in a notebook that was not suitable for the purpose in that pages could easily have been torn out or amended. In addition, any record of the medicine we looked at should be checked by two members of staff when being administered and the MAR also signed by two members of staff. This had not been done.

The majority of medicines that were prescribed to people had been printed on to the MARs which were supplied by the pharmacy. When people were admitted to the home or when a medicine was newly prescribed, the medicine had been hand-written by staff onto the MAR. If medicines need to be recorded in this way by a member of staff, then another member of staff should check the entry for accuracy. This is in line with good practice and as recommended by the National Institute for Clinical Excellence (NICE) guidelines under 'Managing medicines in care homes'. Under 1.14.9 it states, 'Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used'.

The above evidence demonstrates that the provider had failed to ensure that medicines were managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of medicines management were managed safely. Medicines stored in the medicines trolley were in date. We observed a staff member administering medicines to people and this was completed satisfactorily. Medicines to be taken as required (PRN) had been identified separately on the MARs and staff signed to say when these medicines had been given and why. Medicines were stored at a safe temperature and in line with manufacturers' recommendations. Where people administered their own medicines, the process was managed safely and risk assessed accordingly.

Systems had been established in relation to safeguarding systems and processes, but were not always effective. Staff told us they had completed training in safeguarding by listening to a DVD on this subject. However, staff understanding on how to protect people from harm was patchy. For example, we asked one staff member about their understanding and what action they might take if they suspected abuse was taking place. They said, "It's just to make sure the individual is secure and is not at risk of any harm. It's more about drugs and alcohol. If one of the clients [people] is giving drinks or drugs to others, then we have to raise a safeguarding. If it's abuse, I'd let the manager know and chart on a body map". Another staff member told us they had not completed safeguarding training with this provider. Their knowledge and understanding came from other employment. A third member of staff told us they had seen the safeguarding DVD but would be undertaking safeguarding training when they commenced their National Vocational Qualification (NVQ) in health and social care. There was no evidence to show that people were at risk from abuse and improper treatment.

We recommend that the provider looks at their arrangements for safeguarding training so that all staff's knowledge and understanding is current and relevant to their role.

People told us they felt safe living at the home and one person said they locked their bedroom door at night. Another person said that they could go out independently at any time during the day or night, but would return by 10pm. This was because the front door was locked around 10.30pm. If people wanted to stay out later than this, they would let a staff member know. The registered manager said, "People have to ring the bell when they come in for safety reasons". This was so that anyone entering the home could be monitored. Closed Circuit Television (CCTV) was operated in some communal areas of the home. People were aware of this monitoring and a notice in the hallway provided information about the CCTV to visitors. Alcohol was not allowed on the premises and smoking was only permitted in a designated area or in the garden.

Risks to people in relation to their care and support needs had not been fully assessed with regard to the completion of records. Some risks had been identified and assessed with guidance for staff on how to manage and mitigate risks, but other potential risks had not been recorded. We have written further about the lack of detailed risk assessments in the Well Led section of this report.

Where risk assessments had been completed, these were appropriate. Areas such as self-neglect, the potential for aggressive behaviour to staff or others, over-eating and being left on their own were covered. Early warning signs had been identified and advice for staff was recorded in relation to what actions to take. One staff member told us, "It's all about people and potential risks and we discuss these. We have face to face meetings about risks". Where accidents or incidents had occurred, these were reported as needed and investigated. Staff had been trained in fire safety and knew what action to take should the premises need to be evacuated in the event of an emergency.

Premises were managed safely. We asked the registered manager to send us copies of records relating to the management of the premises as these were not available at inspection. After the inspection, the registered manager sent us documents which showed that areas such as fire alarms, fire safety equipment, lift servicing, electrical wiring and gas safety had all been checked and were satisfactory.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. During the day there were a minimum of four support staff on duty and at night, two waking staff. Staffing levels were flexible based on people's support needs. For example, where people asked to be supported at healthcare appointments, an additional member of staff would accompany them. The registered manager said, "During the day, people tend to go out. At weekends, some people visit their relatives". People told us they were happy with the staffing levels and that staff had time to spend with them. We observed that staff did have time to spend with people. Staffing rotas confirmed the numbers of staff on duty during the day and at night and were consistent. The registered manager told us that agency staff were never used and that any gaps would be covered by existing staff or by herself.

Records in relation to staff recruitment were not kept in an orderly way. We were provided with a folder that contained some Disclosure and Barring Service (DBS) checks for new staff. DBS checks are made to ensure the suitability of potential new staff, including any criminal convictions and whether they are fit to work with vulnerable people in a care setting. We saw some application forms and two references had been obtained for new staff. There was no clear method to determine how or whether new staff had all the necessary checks completed or their employment histories checked based on the records we were shown. We asked the registered manager to send us copies of records for four members of staff who were employed at the home, so we could verify all the appropriate documentation was in place. After the inspection, the registered manager sent us the information we requested and this confirmed that new staff had all the necessary checks made prior to commencing employment.

People were protected by the prevention and control of infection. We saw that staff wore personal protective equipment, such as disposable gloves, when dealing with clinical waste and soiled laundry. Staff were trained in infection control. The home was clean and smelled fresh.

Lessons were learned and changes made if things went wrong. We asked the registered manager about their understanding of Duty of Candour. She explained, "It's about doing everything openly, clarity, all parties informed. We work as a team and everyone is involved. We are all aware of what is happening when something goes wrong". A staff member told us, "It's about not keeping secrets. If you see anything happening, you would let the managers know. Or, if it's illegal, let the police know".

Requires Improvement

Is the service effective?

Our findings

This is the first inspection so this key question has not previously been rated.

The registered manager could not fully evidence that staff had completed the training required to provide people with effective care and support. Some training was delivered through videos which staff could borrow. There were videos covering topics such as health and safety, infection control, food hygiene, safeguarding and moving and handling. Staff told us they had looked at these videos, but were unsure which topics they had covered and what was still needed. The registered manager did not have a training plan in place to show the training that staff needed to complete. She said, "I have no training plan, but as everyone [staff] is doing their National Vocational Qualifications (NVQ), we will just get that done. They are being observed by the tutors. I've got loads of materials that staff can access and staff can also look on the Internet". The registered manager added that they were in the process of arranging for a training company to deliver face to face training in the future.

Staff provided examples of some training they had completed. For example, one staff member said that training in infection control, medicines, moving and handling and safeguarding was mandatory. They told us, "Training is really effective because we can help people and promote their health and welfare and keep people from harm". When we asked this staff member how their training helped them to understand people they supported, they said, "I look at people's care plans and it helps me to understand people more and about their mental health. I have a lot of experience working with people with mental health problems". There was no system in place to plan formal supervision meetings between staff and the registered manager. However, staff told us that the registered manager often worked on the floor and would observe staff interacting with people. We saw this in practice at the time of our inspection. We had no evidence that the lack of planned training and supervisions had a negative impact on people or on their health and welfare.

Some staff had enrolled on training such as NVQs in health and social care. There was no induction programme planned as staff working at the service had come from one of the provider's other homes. The deputy manager was new in post, but had a good understanding of the service and people using it, from their previous employment in another capacity. The registered manager told us that when new staff were recruited they would study for the Care Certificate, a universally recognised, work based qualification. The Care Certificate is a qualification undertaken by staff who have had no previous experience of working in a care setting.

Staff did not receive formal supervisions, but the registered manager worked alongside staff on the floor and observed their work regularly. One staff member said that informal weekly supervisions between them and the registered manager involved a discussion of how they were feeling and their job role. These supervisions were not recorded, but the registered manager confirmed they took place. Annual appraisals had not yet occurred with staff because the service had been open less than a year. The majority of staff had not been in post long enough to receive an annual appraisal. We have written further about systems for staff training and supervision in the Well Led section of this report.

All aspects of people's mental, physical and social needs had been assessed. Records showed that the service worked with a number of organisations that provided support to people with mental health needs. For example, people were encouraged to receive support from an organisation with expertise in housing, alcohol and drug misuse, health and wellbeing. This meant that people had access to a voluntary sector organisation which supported them to think about their lives when they left White Pearl Residential Care and promoted their independence.

People were supported to eat and drink enough to maintain a balanced diet and encouraged to follow a healthy lifestyle. Food was prepared by staff in a kitchen off the dining area. People were encouraged to help prepare meals if they wished and this promoted their independence in this area. We observed the lunchtime meal in the dining area. People were asked what they would like to eat and chose from sandwiches, noodles or light snacks, with a range of fillings. The main meal was served in the evening as many people chose to go out during the day. Drinks were freely available and people could help themselves from a water machine, jugs of squash or thermoses of tea and coffee. People were complimentary about the food on offer. One person said, "The food is really good compared to where I was before". A staff member told us, "I love cooking. We have a menu and people tell us what they would like to eat, so we plan for that. We have vegetarians in the house and some people don't eat pork, so we offer them beef for example. I ask people if they like things and whether they want to help with the cooking". One person had a particular medical condition which they explained to us and of the need to eat a healthy diet. They told us that staff supported them in this.

The registered manager and staff worked with a variety of organisations to deliver effective care, support and treatment. The registered manager explained how referrals for people to come to live at the service were completed by social workers and care co-ordinators from local authorities. She said it was important that these professional relationships were developed from the outset, when people were assessed and after they came to live at White Pearl Residential Care. We were told that social workers, for example, met regularly with people and staff at the service to ensure that people received the care and support they needed and their independence was supported.

People were supported to live healthier lives and had access to a range of healthcare professionals and services. Many people managed their own healthcare appointments independently and were supported by staff in this. People had access to national screening programmes and clinics to monitor their health, including psychiatric and mental health support. One person told us they saw their community psychiatric nurse (CPN) every fortnight. They said their CPN would ask them how things were and, "day to day stuff really", which they found helpful.

People's individual needs were met in the layout of the home. Their rooms were personalised and decorated in line with their choices. People had access to designated smoking areas and to a large garden, which had a decked area furnished with benches and tables. We observed people were enjoying sitting in the garden and there was a gas BBQ for cooking outdoor meals, which was popular. When people wanted to receive visitors or to have private meetings, a quiet room was available. The registered manager said that accessibility at the premises had been altered for one person who was a wheelchair user. For example, a new door had been provided and a ramp to the garden.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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). One person was subject to DoLS which had been authorised by the local authority. This DoLS was flexible in that the person was encouraged to go out independently as part of a plan for when they moved back into the community. Staff had completed training on the MCA. One staff member said, "Yes, I completed training previously. The MCA is if someone can't decide for themselves, it's about decision making". The requirements of the MCA and associated legislation under DoLS had been met appropriately.

Good

Is the service caring?

Our findings

This is the first inspection so this key question has not previously been rated.

People received personalised care from staff who knew them well. People were treated with kindness, respect and patience by staff. We observed people were caring of each other and were courteous and polite in their conversations. Staff provided support when needed, but in a discreet way, respecting people's feelings and how they wished to spend their days. People spoke highly of the staff. One person said, "Staff are really nice and really helpful and they have time to spend and chat". Another person commented, "Staff are excellent and I get on with everyone very well".

People were supported to express their views and to be actively involved in decisions relating to their care. Everyone living at White Pearl Residential Care was able to communicate verbally and expressed themselves independently. One person had been appointed an advocate in readiness for when they were due to leave the home. The advocate would support this person in their decision-making. Another person explained how positive making their own decisions had made them feel. They described this had not been the case when being supported elsewhere. They added how much more comfortable they felt now and that the healthcare professionals supporting them also listened to their point of view. A member of staff described how they had developed positive relationships with people. They told us, "I always talk positively with people. Some people like to keep things to themselves and some will talk more than others. So far everyone's happy. People would say if they wanted something to change".

People's choices were respected. For example, the registered manager told us that some people did not particularly like personal care or to have their rooms cleaned; this was their choice. A staff member told us that some people might object if their rooms were cleaned and things moved around without their permission. The staff member said, "Before I go into someone's room I will always knock and gain their consent". People told us they were not allowed to go into other people's rooms without their consent. We observed staff and people knocked on bedroom doors before entering.

People were treated with dignity and respect and we observed this happening. One person had an accident and needed to change their trousers. Staff pointed this out to the person in a very gentle and unobtrusive way and suggested the person might like to get a clean pair of trousers from the laundry. On the day of our inspection, some people had chosen to have a lie-in and staff respected this. People could choose what time they wanted to get up or go to bed, whether they preferred to be supported by male or female staff and when they wanted to go out. People had their own keys to their rooms which meant they could spend time privately if they wished and come and go as they pleased.

Good

Is the service responsive?

Our findings

This is the first inspection so this key question has not previously been rated.

People received personalised care that was responsive to their needs. However, care plans were basic in terms of the information provided to staff about people's care and support needs. We have written about this further under the Well Led section of this report.

Staff knew people well and the way in which they wished to be supported. Whilst information within people's care plans was minimal, staff relied on conversations with other staff and with people, to understand the best way to care for people. Handover meetings between shifts also enabled staff to receive updates about people and to discuss any care or support issues. The registered manager told us, "People have to have a certain level of independence before admission". This was because people's care was designed with a focus on rehabilitation ultimately. When people were well enough to think about becoming more independent and leaving the service, they were supported by staff to achieve certain targets. For example, one person was independent in taking their medicines and completed a weekly chart to confirm when they had taken their medicines. Staff also checked stock levels of each medicine as a back-up. The registered manager said, "If someone moves out, we can maintain contact to support them, without people being too dependent on us. Funding for support hours has to be there when people move on". If people left the service and moved into more independent living, a phased approach was adopted, so support for people was not withdrawn all at once.

The deputy manager, who was new in post, told us of her plans for taking rehabilitation forward. These plans included keyworkers allocated to people and a buddy system. The deputy manager explained, "I want staff to know what they're dealing with and the clients. It's about leadership and knowing what you're accepting. We want a detailed care plan, risk assessment and any forensic history".

Care plans included information about people's personal histories and the original referral document from, for example, a social worker, provided the basis for drawing up the care plan. The majority of care plans included the original referral paperwork and the registered manager had added some information to this. Care plans included the aim of each intervention that staff should adopt when supporting people, such as supporting a person to live a meaningful life whilst maintaining a good level of mental health. People's assessments of need included information and guidance for staff in relation to their risk of suicide, history of any violence, misuse of alcohol, paranoid delusions, impulsive behaviour and compliance with medicines. The registered manager told us that she was aware that some care plans lacked detail, but that she preferred to wait until people had settled into the service, before writing-up a complete care plan. The registered manager explained that people's behaviours and needs could change drastically from one care setting to another, so it was important to do an ongoing assessment. Records of these assessments were kept.

From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability,

impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Arrangements had not been made to present information to people in a way other than in a written format. However, people living at the service at the time of the inspection did not need information to be provided differently. The registered manager told us that they did not have an Accessible Information policy. They said that if people's needs were such that communication would be assisted, say, with photos or pictures, these would be provided. The registered manager said that accessibility at the premises had been altered for one person who was a wheelchair user. For example, a new door had been provided and a ramp to the garden.

An equality and diversity policy was in place and people's different needs, backgrounds and cultures were catered for. We discussed one person who required support from staff in a particular way. This person had protected characteristics and specific emotional needs which staff helped them with. Three or four people chose to attend church every Sunday and were encouraged by staff in this. People told us they had not been shown a copy of their care plan, but that they could discuss anything related to their care with staff.

People were independent in what they did on a day to day basis, so structured activities were not formally organised. People preferred to pursue their interests independently. People were encouraged and supported by staff in the community. One person said they liked staff to go with them when they went shopping. Another person told us they had plenty to do and liked helping with tasks around the home. They said, "I like to be told what to do and when to do it. I go for walks on my own, go into town or down to the beach. It's about having enough time to do everything really". A member of staff said, "Some people want to go out by themselves and others want to do their own thing. One person goes out all the time. Some people go on holidays with their families". People were encouraged in social activities by staff and to spend time together if they chose.

At the time of this inspection, no formal complaints had been received or logged. The provider had a complaints policy in place. People told us they would talk with the registered manager if they had any problems or concerns.

Requires Improvement

Is the service well-led?

Our findings

This is the first inspection so this key question has not previously been rated.

Systems or processes had not been established in relation to assessing or monitoring the services provided to people. Whilst some risks to people had been identified and assessed and had been recorded appropriately, other risks had not. For example, people were able to go out independently of staff, yet there were no risk assessments in relation to accessing the community. Some people smoked cigarettes, but the associated risks for this activity had not been identified or assessed. There was no evidence to show that people received unsafe care or treatment in relation to the management of risks. Staff knew people well, were aware of any potential risks people might encounter and how to manage them, but there was a lack of records in relation to the management of risks.

We asked the registered manager how they routinely monitored medicines and about any auditing systems relating to the management of medicines. She told us that audits to monitor the quality of the service did not take place, but that she was hoping to set up a system to address this. There was no formal system in place to plan training that staff needed to complete in order to provide effective care and support to people. Care plans did not always provide comprehensive, detailed information about people's care and support needs. Audits had not been completed in relation to any aspect of the service to identify the shortfalls we found on this inspection.

People's views and feedback about the care they received had not been sought formally or recorded. The registered manager told us they had not yet sent out any surveys or questionnaires to ask for people's comments. Meetings did not take place in a formal way, either individually or collectively, where people could discuss the service provided or to make suggestions. Staff meetings did not take place, although staff told us that they did feel involved in the development of the service.

The above evidence demonstrates that the provider had failed to establish systems or processes to assess, monitor and improve the quality and safety of the service provided or to assess and monitor risks. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they hoped to remedy the lack of monitoring systems soon as a deputy manager had recently commenced employment. The deputy manager would be setting up systems and processes to assess and monitor the service. Immediately after the inspection, the registered manager sent us documents in relation to staff training and guidance for staff on medicines management. The registered manager had been pro-active in starting to address the issues found at inspection. The registered manager said, "We have no audits yet. There will be monitoring of food, laundry, cleaning, medication, care plans and surveys for clients, professionals and relatives. We will be doing audits regularly and medicines monthly".

The provider had a clear vision of how they would deliver care and support to people with a range of mental health needs. The statement of purpose referred to providing opportunities for people to recover and re-engage with the local community. The registered manager, deputy manager and staff told us how they

encouraged people to be as independent as possible and the support they provided to enable this to happen. Care provided to people was personalised and appropriate. The registered manager said, "We are very committed and have been doing the job for quite a while now. We do our level best to provide the care people need".

People told us that staff were always available if they needed support or wanted to have a chat. We observed this to be the case and that the registered manager welcomed people and staff to her office if they wanted to talk about anything. Staff told us that they felt supported by the registered manager and that they all worked together well as a team. One staff member said, "I'm getting to know people since I'm quite new. The staff are really helpful and people are really kind and talkative". They added that they felt supported by the managers and were happy to go to them, saying, "They will always find a solution. This is the best job ever". Another staff member told us, "I love working with people and getting to know them. You feel like you're a member of the family, it's like a second home. The manager is really good. We can tell her what we feel, what we want and we can talk about anything". The deputy manager explained the roles and responsibilities of staff and the importance of regular supervisions, which she acknowledged did not take place. She said, "We need to have a staff meeting and allocate what needs to be done. There's not one member of staff who is not committed here".

The service worked in partnership with other agencies. People were referred to the service by local authorities and good relationships had been developed between professionals such as social workers, care co-ordinators and healthcare professionals.

We asked the registered manager how they ensured that data for people was held in accordance with the General Data Protection Regulations 2018 (GDPR). She was unaware of this legislation, but had a good understanding of the need to keep information about people confidentially. There was a policy in place in relation to this. Records relating to people were kept securely. The registered manager told us they felt proud of what they had achieved since setting up the service. She said, "I think I do a very good job. I might not be perfect at paperwork, because I don't always have time. I know papers are important, but I can tell you that my residents are happy. We provide the calmest environment for our clients and we go out of the way to make sure they are happy".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were managed properly and safely. Regulation 12 (1) (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems or processes to assess and monitor the quality of the service provided or to fully assess and monitor risks relating to people. Regulation 17 (1) (2)(a)(b)(e)