Livability

Dolphin Court

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?	Inadequate

Summary of findings

Overall summary

The unannounced inspection took place on the 29 February, 02, 03 and 15 March 2016.

Dolphin Court provides personal care and accommodation for up to seventeen people who are living with a disability. The majority of people living at the service were independent and required limited support with personal care however there was a minority of individuals with more complex needs requiring more support than others.

The service does not currently have a registered manager however recruitment processes were underway to appoint a registered manager. The service is required to have 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.

The service needed to improve their quality assurance systems. Although some systems were in place, effective leadership was needed within the service to drive the improvements identified by the systems. The deputy manager was new to managing the service and required more support from the provider in the interim period whilst a new registered manager was being recruited.

Accurate records in respect of people's care and treatment had not been maintained for people with more complex needs to mitigate risks to their health.

Insufficient members of staff meant people's individual needs could not be consistently met within reasonable time frames. In general people were supported to carry out their own daily interests independently or achieve them with the assistance of staff, if requested. However there was a lack of activities for people with more complex needs.

Management and staff understood their responsibilities and the framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Action plans had been created which identified areas of improvement. However, the lack of management and direction had led to a lack of assurance that appropriate measures were being actioned to protect people's rights and that freedom was not being inappropriately restricted.

Staff supported people to ensure they received access to healthcare services when required. Staff also worked with a range of health professionals, such as speech and language therapists and GPs, to implement care and support plans.

Qualified staff supported people satisfactorily with the administration of their medications. A robust recruitment process was in place and staff were employed upon completion of appropriate checks.

Staff were respectful and caring towards people ensuring privacy and dignity was valued. Care was provided in a way that intended to promote people's independence and wellbeing for the majority of people.

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.

Staffing levels impacted negatively on people's needs.

People were supported to take and store their medications safely. Management responded to concerns appropriately.

Appropriate checks had been carried out making the recruitment process effective in recruiting skilled staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Assurance that appropriate measures were being actioned to protect people's rights was not provided despite management and staff who had good knowledge of legislative frameworks i.e. Mental Capacity Act 2005

There was a lack of monitoring people's health potentially putting people at risk.

Staff were supported to continue training and develop which enabled them to apply knowledge to support people effectively. However supervision was not consistent.

Is the service caring?

Good

The service was caring.

Staff treated people kindly and respected people's privacy.

Positive relationships were created between people and staff, who had got to know each other well and reported a sense of being surrounded by family.

Staff supported people to be independent, in a caring manner.

Is the service responsive?

Good

The service was responsive.

Interviews were being held for position of 'lifestyle support worker' to organise activities within the service for people with more complex needs.

Independent people were being supported to maintain their independence and carry out their own daily activities.

Complaints were responded to in line with service policy

Is the service well-led?

Inadequate

The service was not well-led.

A registered manager was not in place. The deputy manager was new to their role in managing the service and required more support.

Regular monitoring and recording of people's health was inconsistent creating risk to people's health.

People who were able to express themselves were very involved in the running of the service; this was not the case for those with communication difficulties.

Staff felt supported by each other. However, expressed a lack of leadership and direction to promote a high standard of care for people.

Dolphin Court

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.

We inspected Dolphin Court on the 29 February, 02, 03 and 15 March 2016 and the inspection was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law.

We spoke with seven people, six members of staff and the deputy manager. We observed interactions between staff and people. We looked at management records including samples of rotas, three people's individual care plans, risk assessments and daily records of care and support given. We looked at six staff recruitment and support files, training records and quality assurance information. We also reviewed four people's medical administration record (MAR) sheets.

Requires Improvement

Is the service safe?

Our findings

Although people told us they felt safe living at the service saying, "I feel safe here with my stuff" and another person saying, "I have a key to my own room, I feel secure here", we found that staffing levels were not always appropriate to safely meet people's needs.

People that were more independent had positive views about staff support but this was not the case of those who required higher levels of support. Comments were mixed, some saying, "I am independent but if I need to call on staff I know they will be available to help." And others saying, "I have to wait sometimes if they are helping others" and "They need more staff, some people need more help than others." The deputy manager told us that six people required two support workers to provide support with personal care.

Although the deputy manager confirmed with us what the minimum staffing numbers were per shift and this was confirmed by reviewing a sample of rotas, our observations confirmed that there were insufficient staffing levels on the days of inspection. Four care staff were on duty however, one member of staff spent necessary time undertaking the medications round, leaving two staff members to work together to support six people appropriately whilst the other member of staff was unable to support people out of bed as they required another member of staff to assist with moving and handling methods, which left them buzzing their colleagues and waiting for assistance. This resulted in everyone's personal care being completed later than 11:30am. Staff told us our observations were that of a normal day.

Staff felt that more staff were required at Dolphin Court. One member of staff told us, "We could do with more staff as not having an activities person has impacted the staff. We have to prioritise more than I'd like to as there's not enough of us to sit and talk to people when the people would like us to." On the day of the inspection interviews were held for the position of 'lifestyle support worker' to organise activities within the service and community activities for people.

The provider was unable to provide detailed documentation which calculated how staffing levels were determined based on an assessment of support and care required for each individual. The provider informed us that these tools had been implemented into the service after the start date of some of the individuals using the service. Therefore for some people there was no documentation available to show how staffing levels had been calculated for their current needs. The provider advised us that staffing levels were adapted when a change in need was identified. This information was stored at the head office and the deputy manager within the service told us they were not aware of how daily staffing levels were derived. The deputy manager did provide us with an example of a risk and notifications prior to inspection, which had indicated the need for increased staffing levels. The deputy manager told us the increased number of staff reduced the risk impacting on other people using the service, as much as possible, until a solution was found and the risk was removed completely. Nevertheless the deputy manager responsible for the daily operations within the service did not have access to information or the knowledge to ensure the service would be able to meet people's individual needs with the correct staffing levels.

The lack of sufficient staff also impacted on hygiene and cleanliness within the service. Local authorities told

us that they had witnessed uncleanliness in one person's room as food had been left under the person's bed and required cleaning they also told us they had been informed by the service that care took precedence over cleaning the environment due to staffing issues. The deputy manager told us that one permanent domestic staff was on long term sick and since December they have had a domestic clean 18 hours a week and night staff also took on cleaning duties. One person told us, "I keep my place tidy and help [domestic staff member's name] when she comes to clean once a week." People who were more independent were happy to clean their own environments. However, one relative told us family have had to clean the place as it was so filthy. One member of staff told us, "It was fine when there were two of us but now there's only one, things don't get done." The deputy manager told us this was being addressed and we saw agency domestic staff commence their first day during our last day of inspection.

These failings are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had the information they needed to support people safely. The deputy manager who had been managing the service with support from the provider since December 2015 was in the process of reviewing and updating care plans and risk assessments. The provider supplied us with documentation which revealed how they monitor the care plans within the service by running weekly reports to identify any delays in reviewing and updating peoples care plans. The deputy manager advised us that peoples care plans and risk assessments were all created and stored on computer software, and were in the process of being reviewed and updated. The contingency plan, if the computerised system failed, was to revert to hardcopy care plans and documenting by hand. However, the deputy manager and staff told us that the hard copies of people's care plans had not been updated for all people and reliance was placed upon the computerised system. Therefore, an effective contingency plan was not in place.

The deputy manager told us that agency staff did not have access to the computerised system and were reliant on permanent staff who provided information of care and support given to people. The deputy manager told us that agency staff who worked at the service did so frequently and they were happy with the care they provided. Agency staff told us, "We shadow other workers so we get to know the people and their specific needs, we write our daily notes and hand them to the senior in charge that shift and they input them onto the system." Staff confirmed that they input agency staff's handwritten daily notes on the computerised system and that they are impressed with agency staff that regularly attend the service. The deputy manager told us she recognised more efficient ways of communicating information with agency staff and was in the process of implementing these systems. For example a condensed one page profile of people's specific support needs and risk assessments for agency staff, to reduce and avoid any risks while providing support and care.

Care plans printed from the computerised system had current knowledge of the person, current risks and practical approaches to keep people safe when they are making choices involving risk. We saw risk assessments covering areas such as; emotional support while remaining on bed rest, managing finances, managing medication, managing correspondence, mobility and safety when making own food.

Staff told us what they could do to protect people and how people may be at risk of different types of harm or abuse. The service had a policy for staff to follow on 'whistle blowing' and staff knew they could contact outside authorities such as the Care Quality Commission (CQC) and social services. One member of staff told us, "I have had to follow whistle blowing procedures in the past, it's not a nice experience but it is necessary to protect people." The deputy manager told us that safeguarding was part of the staff mandatory training and records confirmed this. The deputy manager had a good understanding of their responsibility to safeguard people and processed safeguarding concerns appropriately.

People were cared for in a safe environment. Staff received training on how to respond to fire alerts at the service. Personal emergency evacuation plans were in place for everyone. There was an Emergency Evacuation Plan in place should the service need to be evacuated and emergency contingency plans implemented. All safety checks were completed regularly and as required. Staff were trained in first aid and knew how to respond in an emergency. We saw one person's emergency buzzer consistently clipped securely to their bed sheets to ensure it was always within easy reach when on bed rest.

An effective system was in place for safe staff recruitment. This recruitment procedure included processing applications and conducting employment interviews. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS). Although recruitment documentation was not consistently stored in hardcopy staff files, the deputy manager showed us that all required documents had been scanned and stored on the services computer system, including documents that were absent from hardcopy staff files.

Medication management in the service was safe. Management responded to concerns robustly and appropriately. All staff had received training in medication administration and management. Medicine cupboards and trolley were locked and stored appropriately. Room and fridge temperatures were within safe limits and recorded daily. We observed people being supported to take their medication. Staff asked people where they would like to have their medication administered. Staff administered people's medicines and supported people to take their own medicines dependent on people's choices and required support. One person showed us their dossette box and stated, "They [staff] come to my room in the morning and put them in my dossette box with me so I can take my medications when I need to myself each day." Daily handovers were documented and signed between senior staff which incorporated daily medicine administration record checks and safe transfer of keys and information. We were satisfied that the deputy manager and provider responded appropriately to errors to ensure people's medications were always managed safely.

Requires Improvement

Is the service effective?

Our findings

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. The deputy manager and staff had a good understanding of the Mental Capacity Act. One staff member told us, "You should never assume that someone doesn't have the mental capacity to make decisions."

Staff told us that the need to assess mental capacity had been identified appropriately in one instance and staff documented the need of an assessment in the person's care plan review. The provider had also escalated the identified need to carry out mental capacity assessments where appropriate and created an action plan as such. However, there was no documentation to indicate that the appropriately identified mental capacity assessments had been carried out. The deputy manager stated that they had not been undertaken and was still pending as an action to be completed.

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). Therefore we looked at whether the provider had considered the MCA and DoLS in relation to how important decisions were made on behalf of the people using the service. The deputy manager could not assure us that they had assured themselves, that freedom was not being inappropriately restricted, in one instance.

These failings are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although in general people received good support with their nutrition and they had enough to eat and drink, several areas of support required improvement. Various agency staff were used daily in the kitchen to produce an evening meal. We asked how they were supported to understand the specific dietary requirements of people. They reported to us that the support staff informed them of people's specific needs, alongside the use of the menu which outlined people's meal choices. One member of staff said, "We are told what people need but they need clear visual signs on the wall or in a folder so that all they agency staff know exactly what people will want/need to eat." On the weekly menus we did not see any indications of people's specific dietary requirements or food allergies. This posed a potential risk if agency staff were in the kitchen but also supporting in the dining area. This was brought to the deputy manager's attention immediately and in response menus and documentation was adapted which highlighted clearly to kitchen and support staff people's choices and requirements.

Our observations revealed that people's food was prepared appropriately, when a particular dietary requirement was specified in their care records. One person's care plan indicated that picture menus should be used to involve the person about what they eat and drink. However, when we asked how people with

communication difficulties are given choice they told us, "We know what they would like." No attempts from staff to use tools or methods were seen by us, in order to offer choice when meals were provided. We observed one person with more complex needs eating their meal. Although their care plan stated that can eat independently with support on the preparation of food the person spilt a considerable amount of their dinner because appropriate aids weren't supplied to maintain their independence when eating.

The menu provided alternative options and people said they enjoyed the food and put their thumbs up when they were asked if they liked it. One person told us, "I love the spag bol, pork chops and steak and kidney pie, lots of choice." Some people required support to remain well nourished. One person's care plan contained risk assessments relating to diet and eating specific to the individual's needs and identified the importance of weight monitoring. We spoke with various staff who were knowledgeable about the person, their likes and dislikes, risks of weight loss and specific support and encouragement required to maintain weight, but weekly weight monitoring had not been carried out or documented by staff. In addition one person's care record detailed that they required support monitoring and checking their blood sugar levels. Documents revealed insufficient monitoring of blood sugar levels. Staff and the deputy manager were unable to provide a satisfactory reason why these checks had not been carried out. The deputy manager advised they were aware of the people's weight monitoring needs and would address lack of blood sugar monitoring and assured us people would receive the needs outlined in the care plan and document appropriately going forward.

People were provided with a two course meal in the evenings, five days a week. At the weekends people were supported by staff to make their own evening meals one night and if people chose to they would buy takeaway food another night. One person said, "We've done it for years, I love getting Chinese food at the weekend." Another person said, "They [staff] will make us something else if we don't want takeaway, but I always want it." Some people chose not to be provided with the meal and cook their own meals permanently. One person told us, "It was my choice not to be provided with the meal, I like to keep independent." Another person said, "I like to eat what I want when I want so I do all my own shopping and cooking."

People had access to healthcare professionals. The deputy manager told us, all appointments regarding people's health was recorded within the computer software. We also saw correspondence within people's care records, such as advice from speech and language therapy teams. People told us if they needed to book any health appointments staff would support them to attend if required. One person said, "The girls [staff] come with me to the doctors and book the appointment for me too." One person told us that they had been supported by staff to attend their GP and received regular medical treatment which had resulted in an improvement to their mobility.

Staff received an induction into the service before starting work. The induction allowed new staff to get to know their role and the people they were supporting. We observed a permanent staff member confidently supporting a newly recruited member of staff, who was in the process of completing the Care Certificate. We observed the new recruit shadowing and asking questions to learn about processes of providing care effectively. Another member of staff said, "When I started I shadowed for two weeks and completed my training, I had time to get to know people and felt comfortable with what was required of me." The induction incorporated an array of practical and online training.

Support staff were supported to obtain the knowledge and skills to provide care. Staff told us they received refresher training in the necessary elements of delivering care as well as additional training courses. One member of staff said, "I have had training in epilepsy and administering buccal midazolam, we know how to respond to [person's name] immediately if they are having a seizure." People received care from staff who

had completed nationally recognised qualifications in Health and Social Care. Another member of staff told us, "I recently had training in personal and professional boundaries, training makes you look at your role with fresh eyes." We viewed staff training certificates within staff files.

One person's care record stated "I use an air loss mattress and need staff to ensure this is correctly inflated." There was no documentation to show checks had been made on pressure relieving equipment. Although service users mattresses were at the correct settings the service could not ensure that the equipment consistently provided the person with the correct pressure and was not putting them at risk of obtaining further pressure sores. Staff told us they had not received training on pressure relieving equipment. The deputy manager told us they are currently in the process of implementing online training on the subject of skin integrity as this will develop staff knowledge which can be applied within the service and improve the care given to people.

When asked about supervision and yearly appraisals the deputy manager reported to us that their policy states supervision is required six times in twelve months and supervision and appraisals hadn't been undertaken consistently by previous management within the service. The deputy manager had created a supervision matrix to ensure supervision and appraisals would be completed in line with policies going forward and the providers Quality and Practice Development Manager had begun the process of completing supervision and appraisals for senior staff which we viewed in staff files.

Good

Is the service caring?

Our findings

Staff had positive relationships with people who were supported to be as independent as they chose to be. We observed staff, which although busy performing tasks, were polite and stopped to listen to people and answer their questions. On the day of inspection a gathering was held for a member of staff who was leaving the service. One person told us, "I feel like I'm saying goodbye to a best friend not someone who works here." People told us they liked living at the service. Another person told us, "I've been here a lot of years, seen people come and go, I want to stay." People and staff were really relaxed in each other's company. One person reported, "We are like a family here." There was positive ease of conversation and two way exchanges about staff and people's families, health and wellbeing.

Staff knew people well, their personal histories and support needs. The deputy manager told us they listen to people and try to support any wanted changes expressed by the people. One person told us, "I used to be on the first floor with a beautiful view over the sea front, but it was really noisy in the summer, they [staff] helped me move onto the ground floor, I'm much happier there now."

Dignity and respect was reflected in people's care records regarding end of life plans and people's wishes based upon their religious beliefs. One care plan detailed the person's wishes for care and treatment immediately after death. Staff respected people's privacy whilst ensuring their safety, health and wellbeing. We observed staff ringing the doorbell of a person's own living space before entering. One person told us, "They ring the doorbell if they want to see us when we are in our room, but I leave my door open, it's safe, I like the people."

People were supported and encouraged to maintain relationships with their friends and family, this included supporting trips home and into the community. We observed one person being visited by a relative; staff treated the relative respectfully and the relative was included in the goodbye celebrations being held.

Good

Is the service responsive?

Our findings

Most of the people living at the service were independent and lived full lives however; there was a lack of support to partake in activities of interest for people with more complex needs. The service had been without a staff member to provide activities for a considerable length of time and staff reported they had limited time to just sit and interact with people. One relative of a person with more complex needs told us, "There are no daily activities for them and they haven't been out for a long time." The service was attempting to remedy the situation at the time of inspection. The deputy manager held interviews on the day of inspection for the position of 'lifestyle support worker' to organise activities within the service.

We observed high levels of independence from many people and they chose to fill their days with their own activities. People we spoke to told us about the outings to various places they had been, for example, the civic centre and to London to see shows, the zoo, bowling and out for meals. One person said, "We are lucky, there's also a lot of things in walking distance." One staff member spoke to us about daily activities, "People do things together here sometimes, arts and crafts and reading, although it depends what people want to do, it's their choice and they are very independent."

One person was supported to attend college on the day of inspection. We heard one member of staff handover to colleagues that the person had chosen not to have support from the service with them, although wanted someone at the college to meet them at the other end to show them to the classroom. Support staff informed they had called the college to arrange this for the person. Another person told us, "I go to work twice a week at a children's centre, I can get there myself in my wheelchair." This demonstrated that more independent people were being supported in education, interests and the avoidance of social isolation.

The service accounted for people's strengths and levels of independence. In turn, the service performed as accommodation providing a supported living service to facilitate people's independence and a residential care home supporting more complex needs of others. Staff listened to people's choices which ensured people's individual preferences were supported, such as daily living and interests. We saw one person carrying out an interest of their choice. The person told us, "When I came here I used to make remote control cars but after speaking to the staff here they helped me and now I'm fixing up a motorbike, hopefully get it authorised and adapted so I can use it myself." Another person told us, "I do all my washing, we have a schedule; I like to stay independent."

Although face to face pre-admission assessment forms were not archived within people's care records and could not be located, the deputy manager told us that before people came to live at the service their needs were assessed to see if they could be met by the service. One senior staff member told us, "We travel to the person to see how they live in their own environment and if we are suitable for them." They also explained to us the transfer process which ensured that medications were organised prior to peoples transfer date thereby avoiding any omitting of medicines. People also told us they remembered speaking with the service management about what their needs were before agreeing to live at the service. The provider gave us documentation of one person's individual placement contract and care funding contract which supplied an

overview of the support people agreed to be provided with and how it was calculated initially and for any future reviews.

People's care and support plans and individual risk assessments were very person centred. Support plans contained excellent life history detail; people commonly stated they were like a family as many of the people had lived there for several years. When we asked people about their own support and care plans people were aware of them. One person said, "I know I have a support plan, I don't have to wait for a review if I need anything, I can just talk to the people [staff] here." Another person said, "If they, or me, come across changes to my care they amend it [care plan] in front of me." There was information about how to best support people if they were showing symptoms that might suggest their mental health was deteriorating. We observed staff meeting the support detailed in people's care plans and permanent and agency staff we spoke with knew people's histories.

The service had policies and procedures in place for receiving and dealing with complaints and concerns received. The information described what action the service would take to investigate and respond to complaints and concerns raised. Complaints were documented in line with the policy and we viewed correspondence which showed how staff supported people during a complaints process.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in place and although the deputy manager had been managing the service since December 2015 leadership within the service was ineffective. We were given and reviewed various quality assurance documents completed at the service by the provider. Action plans were created in response to these various reports that were run periodically but these had not been followed up to drive improvement. The deputy manager told us, "It is overwhelming. The staff here are well established and help me when I need it but are busy providing care." The deputy manager was open and transparent and told us that although some support had been given by the provider to help them manage the service, effective leadership had been absent for some time which had impacted on the robustness of quality monitoring in the service. One member of staff told us, "My recent appraisal was the first time in a long time I have felt valued for the job I do, we have lacked direction and leadership here for some time." Another staff member told us, "I didn't realise there would be such little management support when I joined here." Internal reports produced by the provider also identified a shortfall in leadership which impacted negatively on the effectiveness and quality of the service being provided.

Although interviews were taking place for a new manager, the service had failed to assess, monitor and improve the quality and safety of the service provided to people whilst carrying on the regulated activity. They had not maintained accurate records in respect of people's care and treatment. Areas of concern we found were in regards to pressure care records, weight monitoring records, blood sugar levels, fluid and nutritional records, observational check records, infection control audits and lack of monitoring of the service, putting people at risk.

Regular audits had not been completed on pressure relieving equipment, to ensure staff had placed people's air mattresses at the correct settings. We viewed two care plans which stated mattresses should be regularly checked. One care record stated "staff must ensure the mattress is in good working order and is regularly checked." The deputy manager and staff told us district nurses are contacted if the alarm of the mattresses' sound. We were also advised by the deputy manager that the staff did not make checks on the mattress settings to ascertain they were on the right setting for the person. An absence of documentation confirmed this. Also, weekly weight monitoring was not undertaken as outlined in people's care plans. Therefore the service could not ensure that the equipment; provided the person with the correct pressure and was not putting them at risk of obtaining further pressure sores. One person's care record detailed the importance of being weighed weekly and stated "I need to be weighed weekly" to ensure their health and wellbeing and that action could be taken if their needs changed due to weight change. The person's weight was not recorded weekly and their weight had decreased over a period of 4 months. The service did not maintain accurate and complete records in respect of each person's care and treatment, placing people's health at risk.

The service had not effectively assessed, monitored and improved the quality and safety of the service provided to people. The provider used questionnaires to gain feedback on the service. The provider told us that questionnaires were not distributed to relatives, stakeholders or health care professionals to gain feedback in order to identify improvements in the service. Additionally, the responses from questionnaires in

July 2015 were only sent to people that use the service and had not been used to identify any improvements or changes that were needed at the service. The provider reported that the registered manager had been tasked to agree an action plan from people's July 2015 responses, as part of on-going improvements to quality assurance systems. However, this had not been produced at the time of inspection.

People who were able to express themselves were very involved in the running of the service, this was not the case for those with communication difficulties, and no documentation was available to show how the service included these people and their views to continually improve the service they received. Despite these shortfalls most people experienced positive outcomes from their involvement. One person who used the service had been elected as a spokesperson for the people who used the service and was part of the regular house meetings taking place. Minutes of the house meetings were detailed and produced in an easy read format for those that required it. The minutes clearly showed staff updating and discussing improvements which could be introduced. For example, people were informed about hiring of new staff, kitchen updates in flats and new activities. More independent people's views were documented within the minutes.

The deputy manager expressed their purpose was to "deliver a high standard of care for people who we want to be as independent as possible, it is important to know people's personal limits so we can support them to achieve what they choose." The deputy manager also told us that they felt positive having identified effective systems and processes which would help ensure a good foundation for the next registered manager in post to drive improvements. However, the deputy manager recognised that leadership was lacking and more management support was required to implement and develop effective systems and processes to provide a good service.

These failings are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Lack of MCA assessments where appropriate

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Lack of systems and processes to monitor and assess adequate staffing levels.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Personal care	Poor governance resulted in lack of mitigation for risks to people's health. We issued a warning notice because of the level of our concern.

The enforcement action we took:

Warning Notice