

At Home in the Community Limited

Beaumont Court

Inspection report

1-2 Beaumont Court
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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

Beaumont Court is a care home situated in Prudhoe, Northumberland which provides personal care and support for up to eight people with learning and physical disabilities. At the time of our inspection there were seven people in receipt of care from the service. Our last inspection of this service took place in May 2014 when we found the provider was meeting all of the five regulations assessed at that time.

The inspection took place on 2 and 6 October 2015 and was unannounced.

There was a manager in post but they had not registered with the Care Quality Commission (CQC). The manager told us this was because the previous manager, who left the service early in 2015, had not formally deregistered themselves with CQC as the manager of the service and they were waiting for this to happen first. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are

Summary of findings

‘registered persons’. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People appeared comfortable in the presence of staff and we saw they enjoyed good positive relationships. Safeguarding procedures were in place to protect people from abuse and there were channels through which staff could raise concerns.

People’s needs and the risks that they were exposed to in their daily lives were assessed, and these were regularly reviewed. Regular health and safety checks were carried out on the building and aspects of care delivery, to ensure that the people, staff and visitors remained safe.

Medicines were managed safely with appropriate systems in place in respect of the administration, storage, ordering, disposal and handling of medicines. Recruitment processes were thorough and included checks to ensure that staff employed were of good character and suitable for the role to which they would be employed.

We found concerns with the numbers of permanent staff employed and a high reliance on the use of agency staff. The manager told us that recruitment was underway. We found disgruntlement amongst the staff team which had not been identified by the manager and therefore not addressed. Staff training had fallen behind in key areas such as safeguarding and staff had not been provided with training specific to the needs of people that they supported. Supervisions had fallen behind for some staff and appraisals had not been completed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their ‘best interests’ and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals. The manager told us that no applications had been made to the local authority safeguarding team to assess whether people needed deprivation of liberty safeguards to be put in place. The ‘best interest’ decision process was followed in practice, but these decisions were not always fully documented

within people’s care records. The manager gave their assurances that records held in relation to this would be improved. This meant the provider was not adhering to their responsibilities under the MCA 2005.

People’s general healthcare needs were met and where there had been any concerns about their care, or a change in their needs, external healthcare support had been requested. People’s care plans and risk assessments had been regularly reviewed and where necessary, amended accordingly. People’s nutritional and hydration needs were met.

Our observations confirmed people experienced care and support that protected their privacy, dignity and where possible, promoted their independence. Staff displayed caring and compassionate attitudes towards people and they enjoyed good relationships. Individualised care records were available for staff to follow and they were very aware of people’s diverse needs and how to deliver effective, personalised care. People enjoyed regular activities within their daily lives and they were supported to enter the community safely.

Systems were in place to monitor the service provided and care delivered. The manager told us that a newly appointed compliance team in the provider’s head office were looking to introduce improved auditing systems. Although we noted the provider had some good systems in place, they had failed to identify the issues that we found at our inspection relating to the application of the MCA 2005 and staffing, or where they had been identified, they had not been appropriately addressed. In addition, the management of the service had not been appropriately addressed in line with the requirements of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009, in that the provider had not ensured that a suitable ‘registered person’ had formally registered themselves with CQC as the registered manager of this service. This matter is being followed up separately with the provider, outside of the inspection process.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to staffing, safeguarding service users from abuse or improper treatment and good governance. You can find the 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?

The service was not always safe.

There were not enough staff permanently employed to support people and there was a high dependency on agency staff.

Medicines were managed appropriately.

Risks to both people and the environment within the home were assessed and managed well.

Requires improvement



Is the service effective?

The service was not always effective

Staff did not receive the support they needed. Supervision and appraisals were not consistently carried out and training in key areas had not been undertaken.

The provider did not meet their responsibilities under the Mental Capacity Act 2005 (MCA).

People's needs were met and they were supported appropriately with nutrition and hydration. They were supported to maintain their general health and wellbeing.

Requires improvement



Is the service caring?

The service was caring

Staff and people enjoyed positive relationships with one another and there was good camaraderie.

People were involved in their care and their privacy, dignity and independence was promoted.

Information was communicated to people in a pictorial format that met their needs.

Good



Is the service responsive?

The service was responsive.

People received care that was appropriate to their needs and which changed as their needs varied.

Care records were individualised and very detailed.

Good



Summary of findings

People lived life to the full, attending day care centres and pursuing activities of their own choice.

Complaints were handled appropriately

Is the service well-led?

The service was not well-led

There was a manager in post but the provider had not ensured that they had registered with the CQC as a registered person.

Systems were in place to check and monitor the quality of the service delivered, but issues we found at this inspection had not been addressed.

People and staff were positive about the manager.

Requires improvement



Beaumont 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.

This inspection was unannounced and took place on 2 and 6 October 2015. The inspection was carried out by one inspector.

We checked our systems and reviewed notifications that the provider had sent us over the twelve months prior to our inspection. Providers are required by law to notify CQC of deaths and other incidents such as safeguarding matters and issues involving the police. They enable CQC to monitor the service. We also contacted Northumberland safeguarding adult's team and Northumberland contracts team in advance of our inspection to gather feedback about the service.

We spoke with three people, three people's relatives, the manager of the service, a quality compliance officer and four support workers. We looked at five people's care records plus a range of records related to the operation of the service including staff recruitment and training files.

Is the service safe?

Our findings

We identified concerns with staffing levels at the service. Staff told us that there were several vacancies at the home and there was a high use of agency staff. We discussed this with the manager who advised us that there were three permanent members of support staff currently employed and eight vacancies for permanent support staff. They told us that they had struggled to recruit permanent staff, but that a new recruitment drive had generated interest and interviews were planned for the coming weeks. Staff told us there was disgruntlement amongst the staff team and we fed back this information to the manager who was unaware of the concerns that staff had raised with us. They told us they would investigate and take steps to rectify the matter through discussions with staff.

Staffing numbers on the days of our inspection were sufficient in relation to people's needs, however, these staffing levels were only achieved by sourcing agency staff onto each shift. Staff told us how the use of agency staff had impacted on people's care at times, for example, where they had not been able to take people out to their activities alone, because they were not familiar enough with people's needs and behaviours in order to support them appropriately. In addition, staff told us that they had to induct and supervise agency staff regularly and this impacted on their own work and took them away from time spent with people. A member of staff told us, "There are not enough permanent staff. Clients families turn up and they see different faces all the time".

We looked at a recent complaint and saw that a person's family had raised concerns about staffing shortages and a high staff turnover rate. One relative told us, "It's been terrible this year with staffing. There has been a lot of agency staff usage and at times they have only had two of their own staff working for them and the rest are agency staff. These agency staff don't know X (person) or others, and there is no consistency. It is worrying and frightening when X (person) is there and we don't know the staff". Another relative told us, "They are short staffed. There has been a high turnover of staff and they don't know X (person)".

We found that there were not enough staff permanently employed by the service to meet people's needs and ensure safe staffing levels.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled 'Staffing'.

People who could converse with us told us they felt happy and safe living at Beaumont Court. One person said, "I'm safe here". Another person told us, "I'm never unsafe here, I feel comfortable". In relation to staff practice, we had no concerns about people's safety or how they were supported. One relative commented, "I don't think for one second that X (person) has been badly treated".

Risks that people were exposed to in their daily lives had been appropriately assessed and documentation was in place for staff to refer to about how to manage and mitigate these risks. These risk assessments were regularly reviewed and amended when people's needs changed.

Environmental risks within the home had also been addressed. For example, utilities were serviced regularly and health and safety checks were carried out on a weekly basis. Emergency planning had been considered and a file was in place for staff to refer to should they need to take steps to protect people's safety in the event of an unforeseen incident. This file contained emergency contact details of management within the service and also local specialised external contractors who could be contacted, for example, if there was a plumbing emergency. Each person living at the home had a personal emergency evacuation plan (PEEP) in place which detailed the assistance they would need to evacuate the home in an emergency such as a fire. Both of the main entry and exit points to the building were alarmed to alert staff in the event that a person entered or exited the building undetected.

Accidents and incidents that occurred within the service, or when people were out and about in the community were recorded, monitored and reviewed. We could see that action had been taken where necessary to prevent repeat events from occurring, such as amendments being made to people's risk assessments or changes in staff practice. This showed the provider sought to protect

the health and safety of people and staff.

Staff were aware of what constituted a safeguarding incident and how to escalate any concerns about people's care or treatment that they may have. The service maintained a safeguarding log which showed two safeguarding incidents had occurred within the 12 months

Is the service safe?

prior to our inspection, both of which had been notified to relevant parties. Neither case had progressed into safeguarding procedures and we saw the service had dealt with both matters appropriately and in line with their responsibilities to keep people safe.

Medicines were managed safely. There were policies and procedures in place for the safe administration, storage, disposal and recording of medicines given. Information was available to staff about different types of medicines for them to refer to where necessary. We cross referenced five people's medicines stocks with their Medicines Administration Records and found that the remaining balances tallied with the medicines recorded as having been administered. Where people had left the home to spend time away with their families we saw that there was a robust system in place to sign medicines out and back

into the home. The receiving party took responsibility for supporting the person to take their medicines. There was a lack of individualised information about when staff should administer medicines that were prescribed to be taken "as and when required". We discussed this with the manager who told us that this matter would be addressed immediately.

Thorough recruitment procedures were followed when staff were employed. We looked at six staff files and found that appropriate pre-employment checks were carried out including, seeking references from previous employers, Disclosure and Barring Service checks (DBS) and verifying potential staff's identity before they started work. Application forms were completed, interviews carried out and formal letters of appointment issued.

Is the service effective?

Our findings

Staff told us that they felt unsupported by the service as they did not always know where the manager was as they spent their time between this service and another of the provider's sister homes nearby. Staff told us that although they could contact colleagues at the provider's head office during normal office working hours, and members of the management team via an on-call duty system out of hours, at times they felt isolated and unsupported. One member of staff told us, "We don't see managers very often. Sometimes they come two or three times a week and then not for weeks. Sometimes head office have to look for them. I don't feel supported; we are just left here".

We looked at six staff files and reviewed the supervision and appraisal support that staff had received. We found inconsistency in the numbers of supervisions that staff had received. Some staff had received more regular supervision than others and only one member of staff had received an appraisal, but this dated back to 2012. We discussed this with the compliance officer and manager who acknowledged that staff supervisions had fallen behind for some people and that the appraisal system that was in place had not been appropriately managed, leaving staff without formalised feedback and support.

Training records showed that staff had received training in areas such as fire safety and moving and handling, but they lacked formalised training in key areas such as safeguarding. In addition, staff told us they had not received training such as learning disabilities awareness and autism, which were specific to the needs of the people they supported. The provider did not ensure and satisfy themselves that staff were fully equipped with the correct skills and competencies in order to confidently and correctly support people.

Staff told us that although they recognised gaps in their training, they did not believe people's care was affected by this and we saw no evidence that this was the case during our visits to the home. Staff appeared to know people and their needs very well and how to support them appropriately. People's care records contained detailed information for staff to follow and newer staff told us that where their knowledge was limited, they had learned how to support people from more experienced members of staff who had worked with some of the people living at the home for many years. One member of staff said, "The care

is not affected; the clients are well looked after. However, I have not been as supported as I feel I could have been. I have not done safeguarding training but other staff have told me about it". An induction was in place and although this introduced new staff into the service, it did not ensure they received key training. We discussed our findings with the manager and quality compliance officer. They stated that training was currently being reviewed across the organisation and our findings would be incorporated into any on-going discussions, with the aim that a list of key topic areas are identified as essential training for all staff working at this service.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled 'Staffing'.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals.

We reviewed how the MCA had been applied in respect of care delivery and whether due consideration had been given to people's levels of capacity in a variety of areas. We found that decisions had been made in people's 'best interests' in line with the MCA. However, written evidence detailing how some individual decisions had been made, and by whom, was not always available. For example, a best interest decision had been made by a GP, family members and care staff that one person should not have an invasive medical procedure carried out, but this was not appropriately documented as a best interest decision within the person's care records. In another case the manager told us that a person had recently had a dental procedure and could not consent to this, and the agreement for this to take place was taken by the person's dentist, family member and care staff. We discussed this with the manager who said that records about such decisions would be reviewed immediately and in future, more detailed information would be maintained.

People in receipt of care from the service had not been appropriately assessed in terms of their ability to manage their own finances. We found robust accountability systems

Is the service effective?

were in place and there was no evidence of any improper or inappropriate management of people's finances. However, we referred the relevant individuals to the commissioning local authority finance team, for them to review the arrangements in place and the provider's involvement in people's financial affairs.

The manager told us that no-one currently living at the home had a granted DoLS authorisation in place, and that although most people were deemed to be lacking in capacity, applications had not been made to the local authority safeguarding team for assessment. The need for these applications to be submitted had not been identified prior to our inspection. This meant that people potentially had been, and continued to be, deprived of their liberty.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled, 'Safeguarding service users from abuse and improper treatment'.

People told us they were happy with the care they received. One person told us, "The staff help with showers. I'm happy". One person said, "I like a lot of things here. Staff are doing a grand job looking after us. I do stuff for myself, but staff help me if they need to. We looked at the latest feedback from family feedback questionnaires sent out in 2014. One comment read, "The care which X (person) receives is excellent. I have no worries as I know X (person) is well looked after by management and staff. Everyone does their job well". Relatives told us staff had called the GP when their relation needed support in this area and they had no doubt that medical attention would be sought whenever needed.

Relatives commented that there was a lack of communication from the service and they did not always feel fully informed. One relative said, "We are quite happy, but communication could be better". Another relative said, "There's been a lack of communication. I don't know what it is, whether it is the leadership, or something else". We relayed these findings back to the manager who said they would look to improve communication channels with families.

Staff were very knowledgeable about people's care needs and they used such knowledge to provide personalised

and effective care and support. Due to the nature of some people's conditions, staff told us they had learned to communicate effectively with people in non-verbal ways, and to interpret their expressions and behaviours to establish their mood or what they were trying to communicate. Staff told us about people's behaviours and some of the challenges they faced and we saw that the information they gave us tallied with detailed information in people's care records.

Records showed that people were supported to attend routine healthcare appointments when required, such as those with an optician or in a specialist hospital setting. There was evidence that where required, people had input into their care from specialist healthcare professionals such as psychiatrists or challenging behaviour specialist teams. This showed the provider supported people to maintain their general health and wellbeing and responded promptly to changes in their care needs.

People were appropriately supported with their nutrition and hydration needs. The manager and staff told us that no people living at the service had any specific dietary requirements although for weight management reasons some people were offered healthy food options. There was a variety of healthy food options available to people, and staff informed us all meals were home-cooked on the premises. Staff told us they consulted people about weekly menu options and that this was flexible with alternative foods being prepared if people did not like or want the meals planned for that day. One person commented on the food and said, "The food's alright here. I had salmon, mixed veg and sauce, and mashed potato last night".

The premises had been adapted to suit people's needs. For example, where there was a change in floor level between the two buildings which had been converted into one adjoining space, edging and brightly coloured tape had been placed on the end of the steps to draw people's attention to them. Handrails also had brightly coloured tape fixed to them to draw people's eye and light switches had illuminating strips attached, to make them stand out in dimmer light. Bathrooms had been adapted to wet rooms on the ground floor, and equipment was available in these areas to assist people and staff in the delivery of personal care.

Is the service caring?

Our findings

We observed staff were caring and kind to the people they supported and there was a calm, comfortable atmosphere within the home. Those people who could, told us that they liked the staff team who supported them. Some staff who had worked at the home for many years had developed strong professional relationships with people. Staff and people enjoyed a sense of camaraderie and it was clear that they knew each other well and were comfortable in each other's presence. We heard lots of laughter in the home between people and staff and respectful conversations taking place. For example, we heard one person and a particular staff member regularly asking each other if they were alright. Their questions and replies were a form of banter and included, "Are you alright sir?", "Yes I'm fine thanks" and "Good man!" Both the person and the staff member appeared to enjoy their relationship and the jovial banter they engaged in with one another.

People's relatives told us that they found staff caring. One relative told us about a time when a staff member had returned to the service on their day off, without pay, to celebrate their relation's birthday with them. They said as relatives they had really appreciated this kind act.

People were well groomed and presented. They looked happy and appeared well cared for. Staff engaged with people when delivering care and support, and they were not rushed when assisting them. Staff informed people what they were going to do in advance of any interactions with them and people were involved in their care. For example, one member of staff said to a person, "We could go for a walk this afternoon, does that sound like a good idea?" In another instance the television was very loud and a staff member asked all people present in the lounge area if it was alright for them to reduce the volume. When everyone agreed the staff member turned the volume down and asked everyone if they could still hear the television.

People were involved in the service via regular meetings with their keyworker who reviewed their care with them and supported them to set goals that they wanted to achieve in their lives. Documentation across the service was presented in a pictorial format that met people's needs

showing the provider communicated with people appropriately. For example there was pictorial information for people about how to make a complaint and within their own personal care records. Environmental health and safety checks were carried out weekly by people who lived at the home, with support from staff and the templates that they completed were pictorial. People had signed their care plans and other documentation which evidenced their involvement in their care planning and care delivery.

People were respected and their dignity and privacy maintained. We saw staff knocked on people's bedroom doors before entering and waited to be invited in. Some people had locks on their bedroom doors and they secured these whenever they were out of the building or if preferred, when they spent time in communal areas. Staff were mindful of people's dignity and we saw one staff member encouraging a person to pull a shower curtain across the entrance to the downstairs bathroom area, before sitting on the toilet in view of anyone passing. Staff told us that this person habitually did not close doors behind them when going into the bathroom, so for privacy and dignity reasons, a shower curtain had been fitted to the communal bathroom downstairs which the person had been encouraged to pull over when using the facility.

People were encouraged to be independent in a variety of ways. Many people attended activities within the community. As far as possible they were encouraged to travel to these sessions independently from staff who worked at the service, but they were supported by staff linked to the day centre, who operated a communal transport service.

Where people needed specialised equipment, such as plate guards, to enable them to eat and drink independently, this was provided.

The manager told us that nobody using the service at the time of our inspection had an advocate acting on their behalf; other than those family members who were actively involved in their care. Advocates represent the views of people who are unable to express their own wishes, should this be required. The provider explained that they would contact people's care managers to arrange an advocate should they require one in the future, if they had no family members who were both willing and able to support them.

Is the service responsive?

Our findings

People told us they were happy staff would respond to their needs. They made comments such as, “I would tell staff if I wasn’t happy and they would help me” and “I like living here. The staff are friendly and helpful, and nice”. People enjoyed telling us about their lives, their pursuits and time spent with their families. They showed us pictures within their rooms and achievements they had been awarded.

Care was person centred and had been assessed initially at the point that people entered the service. Staff explained that where people could not communicate verbally, they had learned to interpret their behaviours and what they meant. Detailed information about certain behaviours people displayed was retained within their care records for staff to refer to. Care records were individualised and written in the first person. They provided the reader with information about the person, including their health and care needs, communication skills, risks that they were exposed to in their daily lives, likes and dislikes, medication needs and goals for the future. Staff were armed with the key information they needed to ensure the care they delivered, was both appropriate and safe. For example, there was information about how staff should respond and what distraction techniques to adopt when a particular person became distressed. There was evidence that care records were regularly reviewed and updated where necessary.

The service operated a keyworker system where individual staff members were allocated to different people living at the home. These staff members held the responsibility for ensuring that the person they were keyworker for, received the most appropriate care for their needs and that their care records were kept up to date.

Care monitoring tools such as behavioural trend analysis charts, sleep charts, incident charts and seizure logs were in use where required. In addition, the provider carried out monthly health reviews which showed any health

appointments that had been attended and any up and coming appointments or health issues that needed to be addressed. People were weighed weekly so that any variations in their weight could be identified and wherever necessary, external healthcare input into their care sourced. This showed the provider closely monitored changes in people’s needs and had the ability to promptly adapt care delivery in response to this. Within the staff team a diary was in use to record up and coming appointments and to pass messages between the staff team to ensure continuity of care as much as possible.

Staff promoted choice throughout our inspection and people were offered options around where they spent their time, what they ate for their lunch and whether they went out into the community. People pursued a range of activities individually, and sometimes together. Some people attended local day care activity centres during our visit, and one person enjoyed telling us about their involvement at a local allotment area where they grew and cultivated vegetables. This showed the provider supported people to pursue activities they liked, which in turn developed their social skills and involvement within the community.

We reviewed how the provider handled complaints received within the service. Records showed the provider investigated complaints appropriately and they responded to complainants formally keeping paperwork for future reference. Historic compliant handling showed that the provider took the necessary action to bring matters to a satisfactory close. The provider had a complaints policy in place, explaining how complaints would be handled and the timescales involved and we saw this was followed in practice.

The manager told us that the provider issued questionnaires on an annual basis to people and their relatives in order to gather feedback about the service that they delivered. The results of these questionnaires from 2014 showed that people and their relatives gave positive views of the service and were happy with the care and support that they, or their relation received.

Is the service well-led?

Our findings

At the time of our inspection there was a manager in post who had managed the service for the majority of this year, however, they had not applied to become the registered manager of the service with CQC. We discussed this with the manager who advised that they had been formally recruited to their post from an internal position some time ago and it was their full intention to submit their application as soon as practicable. They said they had not done so as the previous manager, who had left the service in early 2015, had not yet deregistered themselves from the CQC register. We informed the manager of the need to submit their application without delay.

We received positive feedback from people, their relatives and staff about the manager, although staff told us that at times they felt issues they reported were not always addressed by the provider, or alternatively, they were not informed of the outcome of investigations into any matters that they reported. Our findings from the inspection demonstrated there was a lack of openness at times between staff and management as the issues staff shared with us about disgruntlement within the staff team had not been openly discussed or reported to the manager or provider. One member of staff who was due to leave the service a few weeks following our inspection told us neither the manager or provider had explored their reasons for leaving with them, in order to establish if there were any issues they could address to promote better staff retention.

On the first day that we visited the home the manager was not present and staff had not been able to get in contact with them. At 10.30am the staff team were informed by their colleagues based at the provider's head office that the manager was off sick. Staff confirmed that nobody from head office had contacted them earlier that morning prior to them making enquiries, to advise of the manager's absence from work.

We checked staff signing in books and established that the manager had spent limited time at the service over the three months prior to our inspection, although, we noted that a team leader who worked at the service had been present in the home and working there on different days to the manager. Records showed that in the month of August 2015 staff had worked at the service without a visit from either the manager or team leader for 25 out of 31 days. In September 2015 this figure was 18 out of 30 days. We

shared our concerns about the management oversight of the service with the manager, and a compliance officer who supported staff and the manager during our inspection. The manager confirmed that they had been on annual leave for some of the time referred to above, however, they acknowledged that their time was split between two of the provider's services and head office, and the time spent in each service needed to be reviewed.

We noted there was no information for staff about where the manager would be each working day. The manager and quality compliance officer told us that this would be rectified and staff would be informed about the manager's whereabouts on a daily basis, and when this was subject to change. One person's relative told us, "There is no problem with the manager, they are nice, but they are not there enough". Another relative told us, "You used to be able to call to the home and see a manager but you can't now. There are issues with leadership. If you ring head office you can't get a hold of X (nominated individual). To be honest it is worse now than it has ever been, with the management. It is such a shame".

The provider had some good systems in place and was introducing new tools to help them monitor the performance of the service. However, these systems had either not identified the issues that we found at our inspection relating to the application of the MCA 2005 and staffing, or where they had been identified, they had not been appropriately addressed. People were potentially being deprived of their liberty but no action had been taken to ensure that the provider acted in accordance with their responsibilities under the MCA 2005. Staff supervisions and appraisals had fallen behind in recent years and this had led to a culture where staff did not feel their voice was heard or valued. Training in key areas had not been undertaken and this had not been addressed. In addition, the management of the service had not been appropriately addressed in line with the requirements of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009, in that the provider had not ensured that a suitable 'registered person' had formally registered themselves with CQC as the registered manager of this service. We are dealing with this matter outside of the inspection process.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Good governance.

Is the service well-led?

The manager told us that they submitted monthly returns about each individual living at the home to head office. These monthly returns included information such as activities and incidents people had been involved in that month and any behaviours they had displayed. A new operational monthly report had been introduced two months prior to our inspection and this asked the manager for information related to, for example, how many safeguarding incidents there had been in the last month, any changes to staff hours, any challenges and successes that month and general information about how the manager felt the service was performing.

The provider had systems in place to monitor the service including auditing of health and safety within the home

and medicines management on a monthly basis. There was no care plan audit in place but care records were reviewed regularly and we found they were relevant and up to date. Individual records about what actions had been taken in response to each accident or incident that occurred at the service were recorded and the manager told us these were sent to head office for review by the provider's compliance team who then made recommendations of any further actions that may be required. The compliance team had recently been established and the manager told us that one of their roles would be to come to the service and carry out an internal audit, which they welcomed.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met: People who used the service did not have their capacity formally assessed to ensure they were not being inappropriately deprived of their liberty. The service had not followed the Deprivation of Liberty Safeguards. Regulation 13 (5).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place. Regulation 17 (1)(2).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care because the provider failed to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed. Staff were not appropriately supported through supervision, appraisal and training. Regulation 18 (1)(2)(a)