Royal Mencap Society

Royal Mencap Society - 1 Sheepfold Avenue

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 January 2017 and was unannounced.

1 Sheepfold Avenue is a residential care home, which provides care and support for up to seven people with a learning disability and other complex needs, including autism and mental health. At the time of our inspection there were seven people living at the home.

1 Sheepfold Avenue is a detached house with communal areas over two floors (ground and first floor). There was a kitchen and shared dining area which was open and accessible to people. A purpose built lift enabled people to move from one floor to the other. There was one lounge that were used both for down time (watching television/movies) and for activities. In the corridor on the first floor, was a small sitting area. There was a back garden and we were told that people helped with the gardening.

The service did not have a registered manager in post at the time of our visit. 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. 1 Sheepfold Avenue has not had a registered manager in post since September 2016. An employed support worker was promoted to a temporary acting manager role in October 2016 and was managing the service day to day. The acting manager told us they had previous experience of managing care services. The acting manager told us, a permanent manager had been appointed but was not due to commence until March 2017.

The acting manager had identified the need to improve the personalisation of care planning within the service. For example, whilst we found that people received appropriate care, the approach to care planning was uniform and did not always reflect the assessed individual needs of a person. The acting manager was in the process of updating the care plans and the target for completion was March 2017.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People told us they felt safe at the home

Systems were in place to identify risks and protect people from harm. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. There were also risk assessments in place to help keep people safe in the event of an unforeseen emergency such as fire or flood.

Accidents and incidents were accurately recorded and were assessed to identify patterns and triggers. Records were detailed and referred to actions taken following accidents and incidents. Reference was made to behaviours, observations and other issues that may have led to an accident or incident.

Medicines were managed safely. People were supported to take their medicines as directed by their GP. Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines.

Thorough recruitment processes were in place for newly appointed staff to check they were suitable to work with people. There were sufficient numbers of staff to meet people's needs safely. People told us there were enough staff on duty and records and staff confirmed this.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The staff had a good understanding of their responsibilities in relation to MCA and DoLS. Staff sought people's consent about arrangements for their care. However, the provider had failed to notify the Commission of four Deprivation of Liberty Safeguards (DoLS) authorisations in accordance with the registration regulations.

Staff received training to help them meet people's needs. Staff received an induction and regular supervision including monitoring of their performance. Staff were supported to develop their skills through additional training such as National Vocational Qualification (NVQ) or care diplomas. All staff completed an induction before working unsupervised. People were well supported and said staff were knowledgeable about their care needs.

People told us the food at the home was good and they were offered a choice at mealtimes. Staff monitored people's health to ensure they had access to other health professionals when needed.

People's privacy and dignity were respected. Staff had a caring attitude towards people. We saw staff smiling and laughing with people and offering support. There was a good rapport between people and staff.

People were involved as much as possible in planning their care. People had monthly meetings with their keyworkers to discuss all aspects of their care. The acting manager and staff were flexible and responsive to people's individual preferences and ensured people were supported in accordance with their needs and abilities. People were encouraged to maintain their independence and to participate in activities that interested them.

Handover meetings held between shifts enabled staff to receive updates about people and their most up to date care needs. Complaints were managed in line with the provider's policy.

There was a stable staff team who said that communication in the home was good and they always felt able to make suggestions. They confirmed management were open and approachable.

A system of audits was in place to measure and monitor the quality of the service provided and this helped to ensure care was delivered consistently. Suggestions on improvements to the service were welcomed and people's feedback was encouraged.

We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe.

People had detailed care plans, which included an assessment of risk. These were subject to a regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Medicines were managed in accordance with best-practice guidelines

Is the service effective?

Good

The service was effective.

Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) which, they followed to ensure people's consent was lawfully obtained and their rights protected.

Staff were trained in topics, which were relevant to the specific needs of the people living at the home.

People were supported to maintain good health and had regular contact with health care professionals.

People were provided with a balanced diet and had ready access to food and drinks.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took

time to speak and listen to them.

People were supported to maintain their privacy.

Staff knew how to communicate with people in an accessible way, according to their individual needs, so they could understand their choices and decisions.

People were consulted about their care and had opportunities to maintain and develop their independence.

Is the service responsive?

Good

The service was responsive.

Peoples care plans were under review and being updated by the acting manager to ensure they were more personalised. The target date for this to be completed is March 2017. We found people's needs were being met, but agreed with the acting manager that care plans could be more individualised.

There were structured and meaningful activities for people to take part in.

People were able to express concerns and feedback was encouraged.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been no registered manager in post since September 2016. A temporary acting manager had been appointed in October 2016, with a permanent manager due to commence employment in March 2017.

The provider had failed to notify the Commission of Deprivation of Liberty authorisations in accordance with registration requirements.

The culture of the staff in the home was positive and they worked well as a team.

The provider sought the views of people, relatives, staff and professionals regarding the quality of the service and to check if improvements needed to be made.

There were a number of systems for checking and auditing the safety and quality of the service.

Royal Mencap Society - 1 Sheepfold Avenue

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 5 January 2017 and was unannounced. One inspector undertook this inspection.

Before the inspection, the provider was asked to complete a Provider Information Return (PIR). This is a form, which asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Due to technical issues at the Commission, we were unable to view the PIR prior to the inspection. The acting manager provided us with a copy of the PIR during the inspection, which we used as part of the inspection. We also checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

As people used various methods of communicating, it was difficult to obtain people's views in regards to, Is the service safe? Is it effective? Is it caring? Is it responsive? Is it well led? , so we spent time observing people in areas throughout the home to see interactions between people and staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We met with six people and observed their care, including the lunchtime meal, medicines administration and activities. We looked around the premises at the communal areas of the home, activity areas and seven people's bedrooms. We also spoke with five care staff.

We looked at the care plans and associated records for two people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records.

The service was last inspected on 1 August 2014 when no concerns were identified.

Good

Is the service safe?

Our findings

The service had policies and procedures regarding the safeguarding of people, which included definitions of what constituted abuse, how to recognise abuse and how to report any suspected abuse. There was a copy of the local authority safeguarding procedures on a notice board in the office so staff had details of how to report any safeguarding concerns. Staff had received training in safeguarding procedures. They had a good knowledge of what abuse was and knew what action to take. Staff were able to identify a range of types of abuse including physical, institutional, sexual, racial, financial and verbal. Without exception staff told us they would keep the person safe, observe the person, give them 1:1 if needed, talk to their manager and if needed report their concerns to the Care Quality Commission and/or the local authority safeguarding team.

Staff said they felt comfortable referring any concerns they had to the acting manager if needed. The acting manager had a flow chart in their policy folder explaining the process, which would be followed if a concern were raised.

Before people moved to the service an assessment was completed. This looked at the person's support needs and any potential risks to their health, safety or welfare. Where risks were identified, these had been assessed and actions were in place to mitigate them. Staff were aware of how to manage the risks associated with people's care needs and how to support them safely. Risk assessments were in place and reviewed monthly. Where someone was identified as being, at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. For example, people living with epilepsy had specific care plans and risk assessments on how their seizures should be managed by staff.

Most people needed support with mobility, some of whom were at risk of pressure damage and other people had additional risks associated with their conditions. All people had moving and handling assessments and care plans. Records demonstrated these were reviewed monthly. People who needed complex equipment such as ceiling hoists or electrically operated wheelchairs had them provided. These were regularly serviced. Where people were supported to move using a hoist and sling, they had their own hoist sling allocated to them, which only they used. They also had full information in their care plan, which documented the exact type of hoist sling they used. Where people were at risk of pressure damage, they had risk assessments and care plans. People's air mattresses were on the correct setting for their weight. Their care plans had full information about their air mattresses. Where people had risks such as choking, they had care plans, which detailed how their safety was to be ensured. For example a person had a care plan which documented they had a tendency to put large food items in their mouth and could be at risk because of this. Their care plan documented actions staff were to take to reduce this risk. We observed that staff followed this care plan.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff did so safely and in line with the prescription instructions. Medication Administration Records (MAR) were in place and had been correctly completed to demonstrate people's medicines had been given as prescribed. Medicines were locked away as appropriate. All staff were trained to administer medicines. The acting manager completed an

observation of staff to ensure they were competent in the administration of medicines. We checked a sample of the medicines and stock levels and found these matched the records kept.

Staff had undergone pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicant's conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Prospective staff underwent a practical assessment and role related interview before being appointed. People were safe as they were supported by sufficient staff whose suitability for their role had been assessed by the provider.

Staffing numbers were adequate to meet the needs of people living at the home. The acting manager told us, West Sussex County Council (WSCC) funded all of the people living at 1 Sheepfold Avenue. The acting manager told us WSCC stipulated and allocated the hours to be provided to people. Peoples care was reviewed monthly and following incidents where new behaviours were observed which might increase or change people's dependency level. This ensured there were always sufficient numbers of staff with the necessary experience and skills to support people safely. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice. Monday to Sunday, there were four care staff on duty from 7am to 2.30pm and from 2pm to 9.30pm. In addition to this, between Monday to Friday, the acting manager worked from 9am to 5pm, offering support and guidance when needed. At night, there were one waking member of staff from 9pm to 7am and one care staff member sleeping at the home, who could be woken if people needed additional support. The service had a 24 hour on call system in case additional management support/guidance and advice was required. Rotas we reviewed confirmed there were sufficient staff to meet people's needs safely. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. For example, for the gas heating, electrical wiring, fire safety equipment and alarms, Legionella testing and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff in how to support people to evacuate the premises in an emergency.

Good

Is the service effective?

Our findings

People were happy with the care and support provided by the care workers. One person told us, "They are all good". When we asked a person if they liked their care worker, they responded by, laying their head on a care workers shoulder, smiling.

All new staff received a full induction, which complied with current good practice guidelines. Inductions also included areas such as the geography of the home, communication systems, policies and procedures and the use of wheelchairs. This training was followed in practice, for example, we saw all staff automatically engaged people's wheelchair breaks when they had finished supporting them. Induction was followed by a minimum of two to three shadow shifts. New staff shadowed staff that were more experienced and did not work on their own until they were competent and confident to do so. We spoke to two new staff, who told us they felt well supported.

The acting manager maintained a spread sheet record of staff training in courses considered mandatory to provide effective care and recorded when staff had completed these. These courses included infection control, moving and handling, fire safety, first aid, health and safety, promoting dignity, equal opportunities and food hygiene. A computer system held details of what courses had been completed by staff and notified the registered manager when updates were required.

Staff received supervisions with the registered manager approximately three supervisions per year and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. Two staff said they discussed work, training, residents, any problems, staffing and any suggestions for improvements. Records showed the discussions that had taken place, together with a review of actions agreed from previous supervision meetings. Staff also received annual performance reviews.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that appropriate DoLS applications had been made, and staff were acting in accordance with DoLS authorisations. However, the provider had failed to notify the Commission of authorisations that had been approved under the Deprivation of Liberty Safeguards (DoLS) and we have addressed this issue in the Well Led section of the report. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consideration and consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams.

We checked people's files in relation to decision making for those who were unable to give consent.

Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests. Records showed that staff had received training on MCA and DoLS. When we spoke with staff, they were able to explain their understanding of this topic. Staff were knowledgeable and were able to apply the requirements of the legislation in practice ensuring peoples day-to-day care and support were appropriate and that their needs were met.

People were supported with eating and drinking and staff showed they understood people's needs. A care worker asked a person if they had enough after they had eaten their main course. The person's eyes lit up and they smiled, clearly happy with their meal.

Care workers sat down to support people when they were eating and drinking and made it a social occasion. Staff supported people to eat at their own pace. A care worker smiled at the person they were supporting, making sure they had eye contact while they were helping them. Staff made sure people were safe when they were eating and drinking. A person was eating their meal independently, a care worker made sure they did not eat too much food each time, so they could swallow safely.

All people had clear plans about eating and drinking. A person had a very detailed care plan about the aids they used when eating, for one person it including the type of spoon and for another person, the type of plate to be used and in relation to where they liked to sit. These care plans were all followed by staff.

People's care records showed that their day to day health needs were being met. People had good access to healthcare services such as dentist, optician and GPs. People's care plans provided evidence of effective joint working with community healthcare professionals. We saw that staff were proactive in seeking input advocacy services, (advocates help people to make decisions that are right for them and in line with their personal preferences and choices) speech and language therapists and other professionals as needed.

The environment of the home was appropriate for people who were living with complex disability needs. There was a purpose built lift that enabled people to move from one floor to the other. Corridors were wide enough for people in wheelchairs, including large wheelchairs, to pass each other with ease. All bedrooms and bathrooms were wheelchair accessible. The outside patio/garden areas were wheelchair accessible. People who lived with complex disability needs had equipment provided individually for them to ensure their safety and comfort. This included a wide range of different types of hoists to support people in moving, including ceiling hoists. Where people needed specialised beds, seating and wheelchairs, these were provided. A person preferred a double bed to a single bed, and one had been provided. The service was well maintained, decorated and furnished in a style appropriate for the people who used the service.

Good

Is the service caring?

Our findings

Staff showed a caring approach to people. They gave people positive reinforcement when they engaged with them. Interactions between people and staff were good and it was clear staff knew people, and people knew staff. One member of staff told us, "It's important to ensure the people we support are treated with respect and dignity". Another staff member told us, "This is their home; we have to respect that. We know them so well, and in some cases, we are all they know. Which makes us their family".

Staff supported people in making choices. A person preferred to spend parts of their day independently walking along the corridors. They clearly enjoyed doing this. Staff stopped and chatted to the person as they went back and forth. They did not stop them from doing what they wished and encouraged them, as this was what they wanted to do. A person lost interest in doing an activity with a care worker. The care worker asked them if they wanted to continue. The person indicated they wanted to do something else and so the care worker started giving other options. The person smiled at one of the options indicating that was the one they wanted to do.

Staff ensured people's dignity. Staff made sure they carefully wiped people's mouths after eating and drinking. They supported people in going to the toilet and cleaning their hands before and after meals as they wished, or needed. A person showed us how their nails had been done that morning and indicated the care worker had helped them to do it in the way they wanted.

Staff showed respect to people. All staff consistently asked people if they could assist them by putting clothes protectors on before lunch. At lunchtime, a person was already at the table, a care worker asked them for permission to move them because another person, who used a large wheelchair, wanted to get past them. They also thanked the person afterwards when they moved them back to where they wanted to sit. A care worker was assisting a person to eat at lunchtime, they said "Thank you" when the person opened their mouth wide enough for their spoon.

Staff supported people in engagement. A care worker helped a person with their laundry task. The care worker said warmly to the person "You're doing well. Keep going" when they did this. A care worker set up the dining table for lunch and explained what they were doing to a person who was sitting at the table and asked them to help where they were able. When care workers were tidying up after an activity, they automatically involved people in supporting them with doing this.

Staff clearly knew people and people appreciated contact with staff. A care worker praised a person when they ate parts of their meal independently. The person reacted with happiness and excitement, clearly enjoying the praise. A care worker supported a person taking photos for a collage. The care worker gave the person encouragement, using eye contact and praised the person for what they were doing. A care worker supported a person with taking their medicines. The person could not communicate verbally. The care worker smiled at the person and the person gave the care worker a beautiful smile back in acknowledgement of praise. Staff all knew people as individuals, and spoke of them in affectionate tones.

Where people showed behaviours, which may challenge or were anxious staff supported people appropriately remaining calm, so matters did not escalate. Before lunch, a person became upset because they missed a relative. The care worker smiled at the person, remained friendly and calm and supported the person to call their relative on two occasions.

A care worker told us about the importance of understanding that the people were not children and needed to be treated like adults. They described how they supported people in deciding what they wanted to do. For example saying if a person did not want to be in one part of the home, they supported them to move to another part. A care worker said, "We know all of them as people."

People's care plans showed the caring nature of the home and how people were respected as individuals. Each person had a communication care plan, which gave practical information in a personalised way about how to support people who could not easily speak for themselves. The care plan gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, and angry or in pain and how staff should respond. On the day of our visit, care workers and the acting manager communicated with people in an appropriate manner according to their understanding. They communicated with some people using Makaton and other people using short words and phrases. Makaton uses speech with signs and symbols to help people communicate.

Staff supported people to maintain contact with friends and relatives. This included helping people to send friends and relatives cards, to speak to them on the phone and to arrange home visits. Staff positively supported friendships that people had outside the service. As part of one person's routine, each Wednesday a member of staff would support them to see their relatives. The person had a care plan in place to support this, to ensure each staff member on duty enabled this to happen.

People's abilities to express their views and make decisions about their care varied. To ensure that all staff were aware of people's views and opinions, they were recorded in people's care plans, together with the things that were important to them. Without exception, staff told us that it was important to promote people's independence, to offer choices and to challenge people where needed to help give people a normal life.

Good

Is the service responsive?

Our findings

Without exception, staff demonstrated thorough knowledge of people's needs. The acting manager had identified the need to improve the standard and personalisation of care planning within the service. For example, whilst we found that people received appropriate care, this was not always reflected in the care plans, which contained unclear information to staff. The acting manager had plans to develop the care plans by March 2017 to ensure they were comprehensive and up to date. For example, the acting manager had identified that people who had individual mobility aids did not have this reflected in the person's care plan. The acting manager also told us that all seven people had their fluid intake being monitored on a daily basis, and their weight checked weekly or monthly, but the care plans did not give guidance to staff as to why. We could see that these areas were not assessed needs and agreed with the acting manager that the care plans needed to be more personalised to ensure people's care plans reflected their actual needs rather than a uniform approach to care. It was, however, clear from our observations that despite the lack of clarity in the care plans, this had minimal impact on the delivery of care being provided.

People's needs were assessed before they moved into the service. The local authority funded each person; an assessment was obtained from the funding authority so that a joint decision could be made about how people's individual needs could be met. These assessments formed the basis of each person's care plan.

The acting manager showed us a person's care plan that had been reviewed updated and made more individualised. The care plan contained detailed information and clear directions about all aspects of their health, social and personal care needs to enable staff to care for them. Care plans included guidance about people's daily routines, communication, well-being and activities they enjoyed. Each person had a profile so staff could see at a glance what was important to the person and how best to support them.

Detailed guidance was in place for staff to support people who presented behaviours that could result in harming themselves or other people. The specific behaviours that the person may exhibit were clearly listed, together with the appropriate response that staff should take and information about what could trigger the behaviour.

People's moods and behaviours were observed and recorded together with any lessons learnt from any incident that could inform future ways of positively supporting the person. People's well-being was discussed at staff meetings, reviewed by the acting manager and health professionals were involved as appropriate.

Activities were not always organised or planned in advance. People decided what they wanted to do spontaneously on the day according to how they felt. People told us this is what they preferred. People enjoyed shopping for food at a local supermarket and were supported by staff to purchase food of their choice, and then prepare a meal.

We observed that people were encouraged to use the garden, as an area to relax in and talk with staff. There were garden seats and garden games that people told us they enjoyed using.

Information about what activities people liked to take part in was recorded in their care plans. During our visit to the service, people were occupied in household tasks, doing laundry, making meals, photography and accessing the local area.

People were asked throughout the day if they wanted to go out in the community. People went out to the shops, for a drive and to a cafe.

Each person was supported by a keyworker who co-ordinated all aspects of their care. The purpose of the key worker role was to ensure people were supported with purchasing their toiletries, accessing activities, communicating with relatives and supporting people to review their care plans monthly.

People's concerns and complaints were encouraged, explored and responded to in good time. The acting manager said that they recorded complaints and compliments, which were kept in a folder dedicated for this purpose. Formal complaints were dealt with by the acting manager who would contact the complainant and take any necessary action.

We observed one person voice some concerns to a staff member on shift, on the day of our visit. The staff member listened carefully to what this person had to say and outlined the action they would take. The person was satisfied with the response that they received.

Staff said that if a person told them something was upsetting them, they would try to resolve things for the person straight away. If they could not do so, they would report it to the acting manager. Staff told us some people could not verbalise their concerns, but changes in their behaviour would alert them that something was not right that might need further investigation. To help people understand the complaints procedure, it was discussed with the person as part of their monthly key worker meetings in a format the person was able to understand.

The complaints procedure for visitors and relatives included information about how to contact the local government ombudsman, if they were not satisfied with how the service responded to any complaint. The acting manager told us in the event of a complaint they would make a record of any complaints, together with the action they had taken to resolve them. However, no complaints had been made in the past 12 months.

Views of the people using this service were sought through an annual questionnaire, which a member of staff, an advocate or relative supported them to complete. Monthly 1:1 key worker meetings occurred which; is when a allocated staff member meets with the person each month to discuss their views on the care they received, activities they would like to do in the future and discuss any changes occurring in the service, for example, décor, staffing or new people moving in.

Requires Improvement

Is the service well-led?

Our findings

Although relevant applications had been submitted to the local authority. The provider had failed to notify the Commission of four authorisations that had been approved under the Deprivation of Liberty Safeguards (DoLS). The provider had failed to act in line with their legal responsibilities. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is part of the registration condition for a service to have a registered manager. A registered manager had not been in post since September 2016. An employed support worker was promoted to a temporary acting manager role in October 2016 and was managing the service day to day. The acting manager told us they had previous experience of managing care services. The acting manager told us, a permanent manager had been appointed but was not due to commence until March 2017.

Quality assurance systems were in place to regularly review the quality of the service that was provided. These audits were carried out by a nominated officer of the provider and the acting manager. There was an audit schedule for aspects of care such as medicines, activities, care plans, finance checks, accident and incidents, health and safety and infection control. Records demonstrated that information from the audits was used to improve the service. Where issues were found, a clear action plan was implemented to make improvements. For example, on the day of an audit it was observed that the handover of staff from one shift to the next was loud and busy, which could have a negative impact on people's behaviour. The handover routine was then moved to a room on the first floor, so that the handover of information from one shift to the other could be done with the least amount of disruption.

Each person had a current assessment of their needs and their preferences were documented. However, we found that care plans contained unclear information as to why certain monitoring was taking place, such as fluid intake and weight recording. The acting manager informed us that they were in the process of reviewing and updating all care plans. The quality audit tool the acting manager used each month evidenced that had been an on-going area of development since they commenced in October 2016. The acting manager had plans to develop the care plans by March 2017 to ensure they were comprehensive and up to date. We agreed with the acting manager that the care plans needed to be more personalised to ensure peoples care plans reflected their actual needs rather than a uniform approach to care. It was however, clear from our observations that despite the lack of clarity in the care plans, this had minimal impact on the delivery of care being provided.

Records demonstrated that people, their relatives and professionals were contacted to attend reviews and update plans where needed. Specific incidents were recorded collectively such as falls, medication errors and finance errors so any trends could be identified and appropriate action taken.

Staff meetings were held monthly. This ensured that staff had the opportunity to discuss any changes to the running of the service and to give feedback on the care that individual people received. Discussion points were mainly around shift changes, key worker allocation, legislation updates, policy, and procedure updates.

Staff said they felt valued and listened to. Staff felt they received support from their colleagues and that there was an open, transparent atmosphere. Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously.

Staff said they felt valued, that the acting manager was approachable and they felt able to raise anything, which would be acted upon. We were told there was a stable staff group at the service, that staff knew people well and that people received a good and consistent service.

People, relatives and professionals were asked for feedback annually through a survey. The last survey was between May 2016. The results of which, were positive. The survey completed by people included their views on the manner of staff, whether they felt listened to, if they had a complaint and if they felt safe.

Two staff explained their understanding of the vision and values of the service. They told us, the ethos of the service was to provide and ensure meaningful trusting relationships were built, that people were respected, all in a homely relaxed environment. Overall staff said their focus was to ensure the quality of care provided and that people and their relatives were happy. We observed these values demonstrated in practice by staff during the provision of care and support to people.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of authorisations under the Deprivation of Liberty Safeguards (DoLS). The provider had failed to act in line with their legal responsibilities. (1) (4) (a)