The Paddock

# The Paddock

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| 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 was unannounced and took place on 18 May 2017. The service is residential service for up 19 people with learning disability and autistic spectrum disorder. There were 15 people living there at the time of our inspection. There are two vacancies as shared rooms are currently used as single accommodation so everyone has their own bedroom. There is no lift to the first floor; some bedroom accommodation is provided on the ground floor but there is limited accessibility to other parts of the ground floor for people using wheelchairs.

There was a registered manager in post. A registered manager is a person who is 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 registered manager had been in post for the last 14 years. The registered manager and the operations manager were both present at inspection.

This service was last inspected in May 2016 when we found that improvements the service had made in some areas had not been sustained in others. We issued requirement notices for action to be taken to improve arrangements for: the storage and administration of medicines, the risk assessment of behaviour and equipment used to support people, the provision of guidance to inform staff about risks associated with specific health needs, the servicing of all equipment and installations in the premises, the appraisal and training of staff, and a robust quality monitoring system that can highlight shortfalls to the registered manager. We asked the provider to tell us what actions they were going to take to address the shortfalls identified and they wrote to tell us what they had done to meet these shortfalls.

At this inspection we looked at whether these improvements had been implemented and sustained. The staff continued to provide care and support that was caring and responsive. Improvements had been implemented to ensure the service was also effective in the care and support it delivered. However, improvements to medicines had not been maintained. Risk management was inconsistent. Improvements in quality monitoring had not been fully embedded and remained ineffective in identifying shortfalls.

People were happy and settled living in the service. People's care needs were understood by staff. Care plans were designed around people's needs and preferences. Relatives were satisfied with the standard of care and felt informed by staff about their relative's needs. Relatives were invited to reviews and were asked to comment about the service through surveys. They commented that staff had the right attitudes and cared about the people they supported.

People were consulted about weekly food menus and enjoyed the meals they received. Staff monitored their health and they were supported to attend regular and specialist health appointments so they remained healthy. An activity programme was in place and people were asked about what they wanted to do; at times people appeared under stimulated. Staff now had the responsibility to support people with onsite activities and needed training and support to be proactive and feel confident of delivering activities

suited to people's needs.

The premises is a grade two listed building that requires an on-going programme of repair and upgrading, the communal lounge, some hallways and bedrooms have been redecorated since the last inspection and provide comfortable environments for people. Other areas such as the dining room and a smaller lounge would benefit from updating and providing a more homelike setting. All tests, checks and servicing of equipment and installations including, gas, electricity and the fire alarm had been kept updated. Staff attended fire drills so they understood how to evacuate the building safely.

There was enough staff to support people when at home and when out in the community. Recruitment checks on new staff ensured new staff were suitable for their role. Staff said they found the registered manager approachable, they felt able to raise issues individually or in a team meeting setting. Staff said they felt supported and the frequency of their supervisions had improved; a programme of staff appraisals was underway. Staff had been trained to recognise abuse. They understood their responsibilities to report and keep people safe from harm. Staff reported and acted on accidents and incidents appropriately.

New staff received an induction to their role that included completion of the Care Certificate. On-going training was also in place for the routine updating of staff knowledge and skills they needed for peoples everyday support, and for specialist areas such as epilepsy, diabetes and challenging behaviour. Policies and procedures that guide staff were kept updated and staff were made aware of any changes.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent on a daily basis and understood how people with limited or no verbal communication made their choices known. DoLS applications were being made for people who lived in the home to ensure that people were not deprived of their liberty unnecessarily.

We have made one recommendation:

We have recommended a reassessment of security and safety of some first floor windows.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Improved practice still needed to be embedded in medicine management. Some health and safety improvements were needed to the premises to ensure people were safe. The assessment of risk was inconsistent and people could be at risk.

Servicing checks and tests of equipment were all in date. Fire procedures and evacuation plans were understood by staff. Staff knew how to keep people safe from abuse. Staff responded appropriately to accidents and incidents.

There was enough staff to support people safely. Improved recruitment checks ensured the suitability of staff

### Is the service effective?

**Good**

The service was effective

Staff were inducted into their role and given training to ensure they had knowledge and skills to support people appropriately. Staff felt supported and received regular supervision and appraisal of their performance.

People's health and wellbeing was well supported. They were consulted about what they ate.

Staff were provided with guidance to support people with behaviours that could be challenging to others. People were supported in accordance with the Mental Capacity Act 2005 (MCA).

### Is the service caring?

**Good**

The service remained caring.

Staff respected people's choices and privacy and dignity.

Relatives felt informed and were made welcome when they visited. People were supported to maintain contact with

important people in their lives.

People were supported and enabled to develop independence skills. They were given opportunities to express their views.

## Is the service responsive?

Good

The service remained responsive.

A complaints procedure was in place and relatives said they felt confident of raising concerns if they needed to.

Care plans were designed around people's specific needs, and took account of their support preferences and things that were important to them. A process for the pre-admission of new people was in place should someone be referred that would take into consideration the needs of existing people.

People were provided with a programme of weekly activities but staff would benefit from training in how to devise activities and promote improved stimulation for people.

## Is the service well-led?

Requires Improvement

The service was not consistently well led

Quality monitoring of service quality and learning from events was still ineffective and led to recurrent shortfalls in compliance.

Relatives commented positively about the service they and staff found the registered manager approachable, staff felt listened to and had opportunities for staff meetings.

Important events in the service were notified to the Care Quality Commission as required. Policies and procedures were kept updated and staff made aware of any changes.

# The Paddock

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 May 2017 and was unannounced. The inspection team comprised of one inspector and an expert by experience that had experience of people with learning disabilities. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR) which they had done. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

We spoke with 11 of the people that lived in the service during the inspection. Some people were not able to express their views clearly due to their limited communication; we spent time sitting with people and observing their engagement with each other and staff interactions with them. This helped us better understand their experiences of care.

At this inspection we spoke with the Operations manager, the registered manager, two team leaders and six care staff. We received feedback from two relatives and three social care professionals.

We looked at five people's care and support plans, activity planners, health records, and individual risk assessments. We also looked at medicine records, menus, and some operational records for the service including: Recruitment and supervision files, staff training records, staff rotas, and servicing and maintenance records.

Requires Improvement

# Is the service safe?

## Our findings

The majority of people were unable to comment about their experiences but we spoke to some people who told us that they felt safe at The Paddock and that they had no concerns regarding their care. One relative told us: "Personally I think it's one of the best, they never have agency staff, he is always happy to go back there." Another said "It's very good, he is very happy there."

At the previous inspection there were shortfalls in medicine administration and storage. At this inspection people received their medicines in the privacy of their own bedroom; this maintained their dignity and privacy. Each person's medicine was stored in a locked cabinet to which only staff had the key. We checked and was satisfied with the arrangements for ordering, receipt and disposal of medicines. All administering staff were trained in medicines and their competency was assessed. Medicine Administration Records (MAR) were completed well; handwritten amendments were appropriately signed. A record of cabinet temperatures was kept to ensure medicines storage did not exceed recommended levels.

Improvements were still needed to the storage and administration recording of medicines as we had previously found that medicines not in the pre-packaged dosage systems were not dated upon opening, we also found that changes on mar charts were not being signed and dated. People had their medicines in their bedrooms; out of four cabinets viewed two people had 'as required' medicines. Only some of these medicines had been dated upon opening so practice was inconsistent. For example a bottle of prescribed medicine administered daily was not dated upon opening. The date of opening was a good indicator for staff to understand the pattern of usage and to inform medicine counts to ensure the right amount of medicine had been administered and could be accounted for. One person was prescribed a number of skin creams and a body chart recorded the names of the creams and where they needed to be applied, whilst this was good practice the body chart in fact recorded different creams to those being administered so the information was inaccurate. A basic medicine audit was conducted by the registered manager each month but this did not provide any assurance that all aspects of medicine management were looked at and aided the registered manager in finding out where shortfalls were happening. The failure to ensure medicines are managed safely is a continued breach of Regulation 12 (2) (g) of the Health and Social care Act 2005 (Regulated Activities) Regulations 2014.

At the previous inspection risks associated with equipment use and risks from behaviour which challenged others were not appropriately assessed and managed. Staff were not provided with guidance in their support of people to ensure they understood and applied risk reduction measures. A review of three care plans in depth and two in regard to risk management however, showed that improvements made had not been applied across all records where similar risks existed. For example, we had previously identified the need for a risk assessment in respect of bedrails, this had happened for the person we had identified previously but had not been similarly applied for another person with bedrails more recently. The registered manager addressed this at inspection. Another person prone to seizures was without guidance on file to inform staff the risk the person was under from their epilepsy seizures and the measures that needed to be in place, before, during, and after a seizure. This would help staff knowledge and awareness and help them ensure the person was kept safe. The registered manager implemented this risk assessment immediately.

A person at risk of skin breakdown was turned regularly by staff and their skin creamed, an air mattress was provided to alleviate pressure. Previously we had asked that the need to check the setting for this be added to room checks in place for the person, this had not happened. The person could not be weighed but their Body Mass Index (BMI) was taken regularly, staff were unclear what this denoted but it was clear this was reducing. Staff thought the person probably weighed between 9-10 stone, their air mattress was set at 95Kg which was approximately 15 stone. An inaccurate pressure mattress setting could increase the risk to the person developing pressure areas. Another person had experienced 13 incidents of behaviour that could be challenging. No risk assessment was in place for their behaviour to indicate the risk reduction measures in place to keep the person and others safe. In conversation staff understood the steps to take, but this was not documented and could therefore be open to interpretation by staff leading to inconsistent responses. The failure to ensure that behaviours or equipment used are adequately assessed for the risk to the person or others is a continued breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises are a grade two listed building with restrictions on what can and cannot be done in the way of modernisation. Recent refurbishment and redecoration had taken place in the large communal lounge, hallways and some bedrooms to provide a more comfortable environment. The dining area and a smaller lounge would also benefit from providing a more homelike appearance. The service was clean. The building experiences some wear and tear but is generally well maintained and staff said the system of reporting repairs and maintenance works well. We noted, however, that three large fanlight windows in one part of the first floor were without restrictors; these could pose a risk if people tried to climb out. Similarly the sash windows were often open from the top instead of from the bottom where the window restriction was in place. This left a large opening for people to get through if they were so minded to and was a potential safety risk.

We recommend that a health and safety assessment by a qualified and competent person be undertaken of the potential risks of current window security on the first floor, to ensure people are not being placed at risk.

Accidents and incidents were responded to appropriately by staff and a record of each accident and incident was made. In most cases follow up action was taken to reduce the risk of further occurrences; however there was no mechanism for formal analysis of incident/accident trends. This could provide greater insight into triggers and root causes; thereby informing strategies for managing incidents or accidents in future. We have discussed this with the operations manager who has requested that all incident/accident alerts are retained in one record for analysis by the operations manager in addition to the registered manager.

At the last inspection the servicing of a hoist and a specialist bath had been overdue and this could place people who needed to use this equipment and staff at risk. We checked the servicing of this equipment again at this inspection and found this was currently in date.

Previously we had made a recommendation that the service seek guidance on the frequency of fire drills for care staff. Staff had received fire training. Visual checks, tests and servicing of fire alarm, emergency lighting and extinguishers were undertaken on a regular basis. A fire risk assessment had been updated and staff understood the action to take in the event of a fire evacuation. Individual personal emergency evacuation plans (PEEPS) were in place to guide staff in the support they needed to provide each person to evacuate them safely from the building. Staff understood fire evacuation assembly points and places of safety to take people. There was improved recording in regard to staff attendance at fire drills to assure the registered manager that all staff were involved in these practices at least twice annually.

A sample of three recruitment files showed required checks had been made to make sure that staff were right for their roles. Full employment histories and references from previous employers had been taken, along with criminal record checks to ensure that staff were of good character. Documents to prove identity had been seen and copied. A statement of health fitness was obtained to help with ensuring staff were fit to undertake their role.

Staff told us that there were enough staff available to support people and ensure they got opportunities to go out to activities in in the community. The staff rota matched the numbers of staff on duty at inspection. Two people had funding to provide them with 1-1 support for a set number of hours each day, the local authority monitored use of these additional hours and told us they were satisfied with current arrangements. There was good continuity of staffing for people with a well-established core group of staff and a decision to fill gaps in the rota from existing staff rather than agency. New staff recruited said they felt well supported and that they had been given time to understand the needs of people they supported.

Good

# Is the service effective?

## Our findings

People told us they could make choices about the breakfasts they ate for example; one person told us they had a choice of different cereals, toast, yoghourt or a sandwich for breakfast. Another said they had porridge with sugar, and another enjoyed "bread and Jam".

People said they all liked the staff, some people knew who their current key worker was (a key worker is a named member of staff with responsibilities for making sure that a person has what they need). People were calm and relaxed with each other and there was a friendly atmosphere between people or towards staff.

At the previous inspection there was an absence of clear guidance for staff in understanding and supporting people with specific health conditions like epilepsy or diabetes. Staff had previously managed these well; with the turnover in staffing however, and the loss of staff knowledge and awareness of how individuals were affected by these conditions, not all staff would understand signs and symptoms or the actions they should take. We checked the relevant guidance was now in place.

At the previous inspection a number of staff had not completed or updated important training such as fire training and practical moving and handling training which helped staff to keep people safe. The registered manager had taken action and the staff training record showed that the majority of staff had completed all their essential mandatory training that included first aid, fire, safeguarding, moving and handling, infection control, food hygiene, safeguarding, mental capacity and Deprivation of Liberty safeguards training. Additional specialist training was also provided to help support those people with more specific needs such as epilepsy and diabetes. The registered manager encouraged staff to achieve additional professional care qualifications and approximately 65% of the staff team had achieved diplomas in health or National Vocational Qualifications at various levels.

New staff completed an induction that followed the nationally recognised Care Certificate standards. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards. Staff worked through individual standards and complete questions around each area, their responses were marked. New staff competency was assessed throughout a three month probationary period. Induction included shadowing other staff, and familiarising themselves with peoples care needs and routines and took in a number of shifts before they joined the rota as a full time member of the team. A new staff member who was new to care had found this process helpful and the mentoring they received from other staff gave them confidence.

Staff received support to understand their roles and responsibilities through face to face discussion and talks with the registered manager every three months. Supervision was documented and staff said they were able to raise issues they wanted to talk about, they felt the registered manager was good at supporting their personal development and they felt well supported and listened to.

A kitchen hygiene rating of four stars had been awarded to the service. Menus were developed from an understanding of peoples likes and dislikes and these were on a four week cycle. People met weekly with a

staff member to discuss what meals and activities they wanted for the week, menus showed which person had chosen. People had a choice of cereals at breakfast and a snack usually a choice of sandwiches at lunchtime, the main meal of the day which was usually in the evening when everyone had returned home from activities. Nutritional assessments were undertaken of those people considered to be at risk and advice sought from health professionals where swallowing or other eating or drinking issues were identified. Some people were prescribed food supplements and others needed a pureed or soft diet. One person needed assistance with eating and drinking and staff provided individualised support to the person around this.

Most people ate in the dining room. We observed staff kindness towards a person with their leg in a cast, asking them where they wanted to eat, and supporting the person into the dining room when they chose to sit at the dining table. The dining tables had been joined up to form one large table. Routines within the service over the years of living together have become somewhat streamlined and perhaps appear institutional. For example, when lunch is ready everyone gets up and makes their way to the dining table, they are all served their lunch they sit in silence and when finished and without prompting return their plate to the servery and leave the room. People however, felt safe with the structures and boundaries in place and became anxious if there were any significant changes. One person told us that their favourite meal was a Chinese takeaway, the carer explained that they used to get it regularly but haven't for a while. People clearly enjoyed the experience of having a takeaway meal; consideration should be given as to whether this can be continued. If not, weekly menus should be adjusted to include cuisine from other countries and give people the opportunity to experience foods they have clearly enjoyed in the past.

Staff supported people with their health appointments, where relatives were unavailable to take them, and people and relatives felt staff responded quickly to health concerns. Care plans showed staff sought appropriate medical attention based on individual needs as and when required. People's weights were monitored to ensure they maintained a healthy weight.

Staff had received training in the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff sought consent, from people in a variety of ways that best suited the person's ability to absorb and handle the information presented. For example one person told us he chose what clothes he wore each day and he would go out with his key worker to buy new clothes. Staff understood that when more complex decisions needed to be made that people might need help with relatives and representatives and staff would help make this decision with or for them in their best interest. The registered manager was aware of actions to take when best interest meetings needed to be held for example, necessary health interventions. The registered manager had taken action to refer nine people for DoLS authorisations and these had been granted and some were in the process of being renewed.

Good

# Is the service caring?

## Our findings

Staff continue to provide a caring service. All the people and relatives that we spoke to indicated to us that the staff were kind and very caring. Relatives told us that they were very happy with the attitudes of staff and how caring they were towards their relatives. One relative told us "when I take him back after a home visit he runs from the car to the home he is so keen to get back". and "They are like one happy family."

Staff were friendly and kind in their support and responses to people, their attitude was respectful and they showed that they understood people's individual characters and needs. We observed staff interacting with people and noted they had good relationships with them all. Staff were compassionate and considerate of their needs. People were comfortable with staff and were happy to be around them and being involved in activities with them.

The majority of people required support to communicate their needs. Systems were in place to support people with this. Staff retrieved a photo album from their bedroom for one person who was having difficulty communicating to us about their family. This was very caring of staff and effective as the person was then able to show us their family members and indicated that many had passed away by indicating towards heaven. The person was able to show us photos of where they had lived before and also a photograph of a bird table that they had helped to build and was very proud of. One of the person's albums had symbols and pictures to which he pointed at to communicate, the staff used this effectively when enquiring what he wanted to drink with his lunch.

Staff were thoughtful about the needs of people and how improvements could be made to their quality of life, for example one person who was cared for in bed had been moved to a lighter airier room on the ground floor; this had lots of windows which looked out onto the garden. The person when awake and sitting up could watch other people when they were out in the garden undertaking activities or going to and from the activity centre. We observed staff tending to the person and they showed great compassion and kindness towards them. They chatted conversationally to the person recalling previous events the person was involved in and laughed about these. It was clear staff had great affection for the person and took great care in ensuring their needs were met and they were comfortable.

The service staff had responded well to the unexpected change in need for a previously mobile person who had broken their leg. Their temporary immobility meant they needed to be moved by wheelchair and a 'special armchair' was utilised for their comfort when they were out in the communal areas. This was stored safely away when not in use so it would not be a hazard to people or staff.

People's bedrooms were on two levels and the hallways to the bedrooms were painted in a light colour and were in good condition, all of the doors were the same colour (white) and had numbers on them, people knew where their rooms were and did not seek to go into other people's rooms but there was no personalisation to the outside of the doors indicating who lived within.

A number of people were happy to show us their bedrooms, these were comfortable and personalised. One

person's room was decorated with mementoes of sports achievements and other personal items, they showed us that their remote control was not working; a staff member removed the batteries and checked a second remote which was without batteries at all. The staff member assured the person she would get some which pleased the person and later during the day the person approached us to let us know the batteries had been replaced and was very pleased about this.

Another person's bedroom was very minimalistic. We spoke with staff about this and they confirmed that sometimes the person could not tolerate the personal effects in their room; these were destroyed if not removed for safekeeping. A relative confirmed this happened from time to time and that the staff understood how to support the person during this time and would reintroduce items when it was safe to do so.

Staff protected people's dignity and privacy by providing personal care support discreetly, respecting confidentiality and speaking about people's needs with other staff in privacy. Staff showed that they were very familiar with people's different methods of communication to help them understand people's wishes in regard to everyday care and support decisions.

Staff knew who the important people were in the lives of the people they supported and could talk to them about them. Staff were aware of people's social history and where they had spent parts of their lives. Peoples care plans contained information about important people and important events in their lives that staff needed to remind them about.

The registered manager had recorded peoples and their relatives' wishes and preferences in respect to end of life decisions where this had been communicated.

Good

# Is the service responsive?

## Our findings

The service has continued to be responsive to the needs of people. A relative said "I do often wonder if they have enough to do". Several people were able to tell us about preferred activities they enjoyed. People could not always recall when they been to activities which were not regular events for example going to the fair, going to the garden centre in a nearby town. Some people participated in regular weekly activities that they were support to go to. For example one person said they enjoyed arts and crafts which they went to on a Friday but had decided that he did not want to go out anywhere on the day of inspection. Another person told us about things they liked to collect and staff said they helped with this.

At the beginning of inspection all but one person was up and had breakfasted. A few people were waiting to go out to activities. People had their own activity planner which reflected specific interests they had. Daily reports, risk assessments for outings and the staff communication book provided information about the range and frequency of activities people were provided with. People had a mix of external and in house activities developed from an understanding of what interested them or they were known to like or prefer. Time was also set aside within weekly activity planners for people to do activities of their own choice, such as listening to music, or watching favourite DVD's. Staff provided opportunities for people to go out at the weekends and the activity offered was dependent on the weather and whether a driver was available to drive the minibus.

People told us they went out to the shops, to the pub, for drives in the minibus, meals out, walks or visits to family members. In response to the reduction in number and increased expense of external organised activities the registered manager had developed an activity centre on site. This was always staffed by one carer when in use. A carer present explained that people were offered one to one time in the activity centre once per week. There they were enabled with staff support to do their own laundry, perhaps some cooking or use the computer and art / craft materials. The cabin was well equipped and comfortable and was a pleasant place for people to visit. In the absence of dedicated activities organiser staff were now rostered to support the activities centre; a number said they were enjoying this aspect of their work.

During the day people were often seen wandering around the service and lacked stimulation. Outside of the times of their allocated activity. People congregated in the main lounge or entrance hallway; staff checked on them regularly and asked if they were okay. We noted that a staff member played a short game of catch in the lounge which people seemed to enjoy. In the lounge and dining room there were drawing materials and board games but we did not observe people being encouraged or supported by staff to use these. Apart from one person who was knitting other people although calm and relaxed lacked stimulation. There was an absence of new technology to provide other forms of entertainment to people and which can be programmed to aid communication for those with limited verbal skills were not in use; staff showed interest in developing this within the service in future. This is an area we have identified as requiring improvement.

People really enjoyed the activity centre sessions. Whilst at the activity centre we asked staff about how they would get help in an emergency. They showed us a panic button on the wall but did not know whether this

worked or was regularly tested. This would not indicate the type of emergency and relied on the staff member being able to access the bell. Whilst there had not been any significant incidents to date we would recommend review of present arrangements.

There was a complaints procedure this was displayed in an easy read format. It would be difficult for most people to understand the concept of making a formal complaint. Staff however, understood people very well and their method of communication. Staff knew when people showed signs of upset or annoyance and said they would look to find the source of this and try to resolve it. Relatives we spoke with said they had not had cause to complain and would not let it get to that stage, they felt they had a good enough relationship with the registered manager that would make them confident of raising any issues directly with them; and that these would be acted upon immediately. The provider information return (PIR) told us that the service had received no complaints during the last 12 months but had received a verbal compliment from a care manager regarding the excellent care staff had provided to the service user they represented.

No one had been admitted to the service for many years. One person had recently passed away due to their great age and there were now two vacancies in the service. The registered manager informed us that any referral would have to be considered for the impact this might have on this very close knit group of people who were like each other's extended family. The registered manager had considered the type of person who perhaps might be able to be supported in the service. A comprehensive assessment of their needs would be undertaken first with request for supporting reports from involved professionals. Any admission would be undertaken at a pace to suit the new person and the people in the service. Opportunities would be provided if needed for the person to spend time at the service and for other people to get to know them prior to any final decision being made.

People's everyday care and support was designed around their specific individual assessed needs. This included information about their preferred personal care routines, their methods of communication, behaviour, night time sleep routine and support needed with day or night time continence, so staff knew how to support them and when. The care plan included information about the person's social history and the important people in their lives. The care plan informed staff what people could do for themselves within the limits of their abilities and where there was potential for them to develop further skills. Peoples support plans were reviewed by key workers each month; they reported any changes to a person's care and support directly to the registered manager. The registered manager updated peoples care plans based on the feedback she received from staff. Risk assessments were also amended accordingly to reflect these changes. On a planned basis the registered manager wrote an annual update of the care plan and relatives and important others were invited to attend reviews if they wished. Goals or aspirations the person had previously achieved were noted and new goals the person had identified with their key worker were recorded for them to work towards.

Requires Improvement

# Is the service well-led?

## Our findings

Due to the increasing age of people in the service there were a reduced number of relatives and visitors to the service. Relatives who had regular contact told us that they experienced good communication from the service staff. They told us that they were kept well informed about the wellbeing of their relative. They said they were invited to reviews and were sent information if they wanted it. They were asked for their views about the service both informally through conversations with the registered manager but also formally through surveys which were conducted annually. A social care professional praised the service staff for the good work they had done in supporting a person they represented but felt overall the service had not moved with the times and was very institutional.

At this inspection we checked that actions the provider and registered manager told us they had taken to address previously highlighted shortfalls. We were satisfied that the registered manager had ensured equipment's checks and servicing had been implemented. Guidance for staff had been developed in respect of health conditions such as epilepsy and diabetes. Improvements had been made to the induction and training of staff.

Detailed guidance in respect of how to manage people's behaviours was in place but risks from behaviour had still not been assessed; or the measures in place to reduce the risk made clear. Medicines management had improved but there remained minor shortfalls in consistently dating medicines upon opening and ensuring some medicine records such as cream charts were kept updated. The medicine audit conducted by the registered manager failed to assess all aspects of medicine management so some issues like these were recurrent.

At the previous inspection the system in place to assure the registered manager and provider that all aspects of care and quality were carried out appropriately was ineffective. The service had failed to achieve compliance because issues identified at inspection have not been fully addressed or not addressed at all. The recommended recording of air mattress settings highlighted at the previous inspection had not been implemented and as a consequence the air mattress setting was set wrongly and could pose a risk of the person developing a sore area. Learning from events does not always happen for example, we had previously identified issues with risk assessment of bed rails for another service user and a risk assessment was put in place, the same practice was not applied with another person who also now used bed rails. At this inspection we found that important and more current information about safe practice for assisting one person with food and drink when they were in bed had been lost, so staff practice seemed at odds with professional advice given and could lead to inconsistencies in support.

The registered manager undertook health and safety checks but these failed to record some important safety information for example the security of windows and whether restrictors were working and in place. There was a lack of clarity as to how shortfalls identified in the audit were taken forward and actioned.

Similarly, an infection control audit was undertaken by the registered manager; there was a lack of information as to how issues identified within this had been addressed and resolved. Shortfalls identified in

these audits had no actions recorded and looked therefore as if they were still outstanding.

The Provider information return (PIR) informed us that the provider had made three visits to the service in the last three months but no reports of these visits were available. We have expressed concerns over previous inspections at the inadequacy of the quality monitoring system in place to provide the registered Provider and manager with assurance that all aspects of the service were running well. A piecemeal approach to addressing this has meant that continued breaches in medicines and risks remain and the overall monitoring of service quality remains ineffective. Since appointment the new operations manager had mapped many of the previous shortfalls in addition to those identified by them self into an action plan. Progress towards achieving these was now monitored and the action plan prioritised issues to be actioned into red, amber or green. This could be improved by the inclusion of clear timescales for completion; also the addition of the shortfalls from audits conducted by the registered manager such as infection control, health & safety and medicines. Currently there was no mechanism to ensure these shortfalls were also addressed within the new action plan.

The quality of care people experienced therefore had not been monitored effectively and is a continued breach of Regulation 17 (2) (a) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with in most instances said they found the registered manager approachable and they felt able either individually or at team meetings to express their views. The registered manager had managed the service for approximately 14 years and with a core group of staff was very familiar with everyone's needs and cared deeply about their welfare. A new operations manager had been appointed and was onsite at inspection.

Although staff had shown confidence and ability in reporting issues within the service to other agencies, they felt the appointment of the operations manager gave them an alternative person to go to with concerns, other than the registered manager. Staff felt positive that the appointment of the new operations manager would prove supportive to them and to the registered manager, whom many staff felt had not always received the support required. The registered manager looked forward to having additional support and receiving appropriate formal supervision and appraisal of her performance which she had not experienced for many years.

During this inspection people were calm and relaxed and interested in our presence. Staff were seen to work in accordance to people's preferences and needs and their support was discreet and unobtrusive.

Staff thought communication was good; they said they were kept informed about important changes to operational policy or the support of individuals usually through formal staff meetings which were held regularly. They were given access to policies and procedures, which were reviewed regularly by the registered manager to ensure any changes in practice or guidance, were taken account of; staff were made aware of policy updates and reminded to read them.

The registered manager understood her responsibilities for notifying the care quality commission of notifiable events that occurred in the service and carried this out. The service was not accredited with any professional body but was a member of Kent Integrated Care Association (KICA) which was provider led organisation providing advice and best practice guidance to its members in a number of areas including the regulation of social care.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The was a failure to ensure that behaviours or equipment used are adequately assessed for the risk to the persons or others health and wellbeing is a continued breach of Regulation 12 (2) (a)<br><br>There was a failure to ensure that medicines are managed safely and is a continued breach Regulation 12 (2) (g) |

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<br><br>The quality of care people experienced had not been monitored effectively and is a continued breach of Regulation 17 (2) (a) |

**The enforcement action we took:**

We have issued a warning notice