Somerset County Council (LD Services)

Jasmine

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 1 and 3 June 2015 and was unannounced. It was carried out by two inspectors.

Jasmine provides care and support for up to seven people who have learning disabilities, physical disabilities and/ or autism spectrum condition. People require 24 hour staff support in the home and support to go out. Jasmine provides single story accommodation close to the town centre. There were five people living at the home at the time of our inspection. Four people lived in the main part of the home; one person lived in a small self contained flat.

There was a manager in post who was currently going through the process of being registered with us. 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 and associated Regulations about how the service is run.

People had communication difficulties associated with their learning difficulty. Because of this we were only able

Summary of findings

to have very limited conversations with two people. We therefore used our observations of care and our discussions with people's parents and staff to help form our judgements.

On both days of the inspection there was a homely atmosphere and we saw staff supported people in a caring way. One parent said "The staff we know are all lovely, caring people."

People's parents told us they had no concerns about the safety of their family members. Each thought it was a safe place. One parent said "Yes it's safe. We trust the staff to keep people safe." Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns.

People's medicines were not well managed to ensure people received them safely or effectively. Staff practice in medicine administration was poor and recording was inconsistent.

Although relatives made positive comments about the care provided by staff, we saw communication with people was inconsistent; people's preferred methods were not always used. People had limited choices and interaction with staff as a result of this.

People's privacy was respected. Staff ensured people kept in touch with family and friends. People's independence and autonomy was not well supported by staff. The choice of activities and opportunities for people to go out were limited. People had a choice of meals and drinks, although choice appeared limited.

People and those close to them were involved in planning and reviewing their care. Some people's care plans did not accurately reflect their care needs. Formal reviews of people's care had not been carried out. When people were unable to make all of their own decisions they could not always be assured that others who knew them well were consulted when decisions were made for them.

People's health care was supported. People attended appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs. One parent said "They are very good with things like that."

Permanent staff had good knowledge of people, although staff practice was inconsistent. There was a lack of consistent staffing and staffing levels varied. Staff were well trained but not well supported. Staff meetings were not held; staff were not supervised regularly or appraised.

There were quality assurance systems in place; these were not effective. The management, leadership and staffing of the home had been inconsistent. Complaints to the service were not well managed or recorded. One parent told us "In general we are happy, but there have been lots of changes over the last year."

We found breaches of the Health and Social Care Act 2008 (Registration) Regulations 2009 and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what 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?

Requires improvement

The service was not consistently safe.

People's medicines were not well managed to ensure people received them safely or effectively.

People were protected from abuse and avoidable harm. Risks were identified and managed well.

There were sufficient numbers of staff to keep people safe. Staff recruitment was well managed.

Is the service effective?

Requires improvement

The service was not effective.

People were not communicated with effectively. People's choices were limited.

People and those close to them were involved in their care but people could not be assured that others close to them were involved in making decisions for them.

People saw health and social care professionals when they needed to. They received prompt care and treatment.

Staff received on-going training to provide the skills and knowledge to provide care for people. Staff practice was inconsistent. Staff were not well supported in their roles.

Is the service caring?

Requires improvement

The service was not caring.

People were well cared for although people's independence was not supported.

Staff were kind and considerate. People were not always supported by staff they knew. Staff consistency and numbers varied.

People were supported to keep in touch with their friends and relations.

Is the service responsive?

Requires improvement

The service was not responsive.

Some people's care was not planned and delivered in line with their current or changing needs. People's care was not reviewed regularly.

People's activities and trips out of the home were limited.

There was a complaints procedure in place but complaints were not well managed.

Summary of findings

Is the service well-led?

The service was not well led.

The service was not providing consistently high quality care.

There was a lack of consistent management and leadership of the service.

The systems in place designed to monitor the quality of the service and its compliance with the law were not effective.

Inadequate

Jasmine

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 checked 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 1 and 3 June 2015 and was unannounced. It was carried out by two inspectors.

People had communication and language difficulties associated with their learning difficulty. Because of this we were only able to have very limited conversations with two people. We therefore used our observations of care and our discussions with people's parents and staff to help form our judgements.

We spoke with seven care staff, the acting manager and the local network manager (who oversees some of the provider's services) and one visiting social care professional during our visits to the home. We observed care and support in communal areas and looked at three people's care records. We also looked at records that related to how the home was managed. Following our visits we spoke with three parents and with two social care professionals on the telephone.

Before our inspection we reviewed information we held about the home, including notifications about important events which staff had sent to us. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The provider therefore provided us with a range of documents, such as copies of internal audits, action plans and quality audits, which gave us key information about the service and any planned improvements.

Requires improvement

Is the service safe?

Our findings

People were prescribed medicines to meet their health needs, but these were not well managed to ensure people received them safely or effectively. Each person had a safe place to store their medicines and a care plan which described the medicines they took, what they were for and how they preferred to take them. Staff helped people with their medicines; no one self medicated.

Although staff had received training and had their competency assessed before they were able to give medicines we found their practice to be poor. Staff told us they only helped one person at a time and always checked to ensure the correct medicine and dose was given. However, we saw although two staff were present whilst medicines were dispensed they did not speak with each other to check the medicines were for the right person, the right dose or were being given at the right time as they should have done to comply with the provider's policy. This increased the risk of errors occurring.

One person's medicine records showed that one medicine should have been given 'as and when required'. This had been given by staff every day to its maximum daily dose. This had not been discussed or agreed with this person's GP and there was therefore a risk that this person's medicines administration was unsafe. The records for other 'as required' medicines for this person were incomplete. Although this medicine was given regularly, staff did not record how the person responded to the medicine as they were required to in line with this person's guidelines.

There had been one medicine error since the last inspection. One person missed one dose of their medicines as this had not been given by staff. Staff had taken the correct action when this error was discovered; this included contacting the person's GP for advice. There had also been an unexplained loss of a small number of medicines from one person's monthly supply.

A medicines administration audit had been carried out by one of the provider's senior managers in May 2015 following the medication error and loss. This concluded there was no effective system in place to determine how or when one person's medicines went missing, identified one person's 'as and when required' medicines had been given by staff every day to its maximum daily dose with no referral to a GP and that accurate records were not kept when people took 'as and when required' medicines and the effect these had on each person. Several recommendations had been made in this report to improve medicine administration.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had communication difficulties associated with their learning difficulty. We therefore asked people's parents and they told us they had no concerns about the safety of their family members. Each thought it was a safe place. One parent said "Yes it's safe. We were really worried parents when [their family member] first moved in a few years ago but not now. We trust the staff to keep people safe. [Their family member] stays with us sometimes and are always very happy to go back to Jasmine so they must feel happy and safe there otherwise they would be anxious about going back. "

Staff had received training in safeguarding adults; the staff training records confirmed all staff had received this training. Staff had a good understanding of what may constitute abuse and how to report it, both within the home and to other agencies. The home had a policy which staff had read and there was information about safeguarding and whistleblowing available for staff. Staff spoken with said they thought the home was a safe place for people. One staff member said "I think it is a safe place for people to live. I would have no worries about reporting any concerns." Another staff member said "I would be confident in raising any concerns. I had a few concerns about [one person] which I reported and these were acted on."

Concerns had been raised about people's welfare and safety by visiting health and social care professionals in January 2015, which had led a meeting in February 2015. The service had been subject to a safeguarding procedure and a plan to improve people's safety had been put into place. A subsequent meeting had concluded people's safety had improved. The whole service safeguarding procedure had therefore been concluded, although one person's care was still being monitored to ensure they remained safe until their planned move took place.

There were risk assessments relating to the running of the service and people's individual care. They identified risks and gave information about how these were minimised to ensure people remained safe. For example there were

Requires improvement

Is the service safe?

detailed risk assessments for moving and handling people who required the use of a mechanical hoist. However, some of the risk assessments had not been reviewed regularly and some contained conflicting information. For example people's medicines risk assessments stated staff competency should be assessed every six months but this was being carried out annually.

There were plans in place for emergency situations. People had their own plan if they needed an emergency admission to hospital; the home had plans in place for failure of utilities. Staff had access to an on-call system; this meant they were able to obtain extra support to help manage emergencies. One parent said "They are very good in emergencies. [Their family member] has needed to go to hospital at times due to [a health condition] and staff have always gone with them and stayed. They have always let us know and we also go to the hospital if we can."

We looked at how accidents and incidents were managed. Staff completed an accident or incident form for every event; this was then entered on the provider's electronic reporting system by the manager. This was designed to ensure that each incident was recorded and reviewed. However, details of the action taken to resolve the incident or to prevent future occurrences were not always recorded so it was unclear if this system was fully effective.

People were supported by staffing numbers which ensured their safety. The provider employed a small team of 21 staff to help ensure consistency and so that staff and people in the home got to know each other well. Staffing numbers varied, sometimes dropping below optimum levels, but on both days of our visit, there were always enough staff to ensure people's safety was maintained. One person received one to one support; other people shared the staff on duty. Rotas were planned at least four weeks in advance to help ensure sufficient staff with the right skills were on duty.

The records we looked at showed there were effective staff recruitment and selection processes in place for new staff. Appropriate checks were undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. Staff had to attend a face to face interview and were not allowed to start work until all satisfactory checks and references were obtained. This ensured staff were suitable to work in the home. Two staff members confirmed that all of these checks were carried out before they started working in the home.

Requires improvement

Is the service effective?

Our findings

Staff communication with people was inconsistent; people's preferred methods were not always used. People had limited choices and interaction with staff as a result of this. Two people were able to communicate verbally, although this was very limited. Some other people could use different methods such as sign language, objects or physically leading staff to show them what they wanted. Permanent staff knew people well and would be able to interpret people's speech, body language or non-verbal communication; this was difficult for other staff, such as agency staff, whose work at the home was irregular.

People's care plans contained some detail about how each person communicated. For example, one person's plan explained that they were able to use some sign language. This was confirmed by staff spoken with. However, we saw very little sign language used to communicate with this person during our visits to the home. Another person was said to "respond well" when using objects to aid communication but again we saw almost no use of these. It was noted at this person's recent review that communication methods and plans needed to be improved; it was also stated a speech and language therapist should support this work. The manager was aware of this and was awaiting contact from a speech and language therapist.

There were occasions when people tried to initiate communication with staff, either by saying "Hello" or using other vocal sounds. Staff responses were mixed. One person tried to communicate verbally but was simply given a book by a staff member, although they did not appear to have asked for one. Another person said "Hello" to one staff member who only responded by saying "Hello" back. There was no other interaction although the person did try to communicate further. This meant staff did not use people's preferred communication techniques to ensure people were responded to in the most appropriate way.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's policy confirmed staff should be provided with regular formal supervision and an annual appraisal to support them in their role and professional development. Staff spoken with told us supervisions and appraisals were irregular. One staff member said "We haven't had regular supervisions for quite a while now. I have really struggled with that as they are really important, especially as we have had such a tough time recently." The records we looked at showed that staff supervision was irregular; there were often long gaps between sessions. For example one staff member's records contained an agreement to have formal supervision "every four to six weeks." They had only had two supervisions in 2015. There were no records of any annual appraisals in the last year.

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

Parents told us staff understood their family member's care needs and provided the support they needed. Permanent staff were good at picking up signs that people were unwell or in pain as often people would not be able to say. One parent said "They are very good with things like that. They always call the doctor if they are worried about them being unwell."

Some people were able to make some of their own decisions as long as they were given the right information, in the correct way and were given time to decide. People were not able to make all decisions for themselves and we therefore discussed the Mental Capacity Act 2005 (MCA) with staff. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff had some knowledge about how to ensure the rights of people who were not able to make or to communicate their own decisions were protected. Staff had been trained but this was in 2009 so their knowledge varied. A refresher course was planned for later in the week of the inspection. One staff member said "We have MCA training this week. The last one I did was 2009 so it will be interesting and clear up some grey areas I have."

We looked at care records which showed that the principles of the MCA had been used when assessing an individual's ability to make a particular decision, but this was inconsistent. One person needed a medical procedure which required the use of anaesthetic. The person was unable to consent to this so people who knew them well and health and social care professionals had made the decision to proceed with the treatment in their best

Requires improvement

Is the service effective?

interests. Clear records had been kept of the decision making process. Several decisions had been made in other people's best interest by one member of staff. People's family members and others involved in their care had not been consulted. This was not in line with the principles of the MCA.

People were supported by an Independent Mental Capacity Advocate (IMCA) if they lacked capacity to make all of their own decisions and did not have an appropriate family member or friend to represent their views. The IMCA visited each person and also attended their reviews.

Staff had good knowledge of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. However, staff were not clear who had a current DoLS authorisation in place; their views ranged from "One person has" to "Everyone is on DoLS". We ascertained that DoLS applications had been submitted for each person following a court ruling which widened the criteria whereby a person may be considered to have been deprived of their liberty. Two applications had been approved so far; three were still being considered.

Any areas of people's care which could be considered restrictive had been assessed. For example, one person used bed rails on their bed to help prevent falls and a lap strap when using their wheelchair to ensure their safety. However, we did observe this person also used foot or ankle straps when using their wheelchair. Whilst these had been in use for some time and appeared to be used appropriately, they had not been assessed as part of this person's plan of care. The manager told us this would be assessed.

Staff told us they had varied training opportunities which helped them understand people's needs and enabled them to provide people with appropriate support. All staff received mandatory training such as first aid and health and safety. Staff had been provided with specific training to meet people's care needs, such as caring for people who had epilepsy or those who may display aggressive behaviour. One staff member said "The training is generally very good. They always ask about any training you need. I needed refresher training in how to use the hoists when I came here and that was arranged for me." The staff training records confirmed that all new staff received a thorough induction before they supported people. One member of staff said "My induction was very good, comprehensive. It was a good introduction and I did some of my training during my induction as well."

The staff team were supported by health and social care professionals. Parents said people saw professionals such as their GP, dentist and optician when they needed to. The service also accessed specialist support, such as from an epilepsy specialist nurse, learning disability nurse, speech and language therapist and a dietician. This helped to ensure people's complex health care needs were well supported by staff.

People were encouraged to have a balanced and healthy diet. People had a choice of meals and drinks, although choice appeared limited. For example, staff asked people if they would like either "tea or coffee" but no other choices; on only one occasion did we see the actual jars of tea and coffee being shown to help people make an informed choice about the drink they would like.

People's nutritional needs were assessed; staff were knowledgeable about each person's different nutritional requirements. Some people needed their food prepared in a certain way such as people who needed a soft diet. A speech and language therapist had been involved in assessing suitable diets for people. Staff demonstrated some knowledge of special diets, but there was no clear system in place to monitor daily food and drink intake for the people in line with these diets. There were menus in place but staff were not clear if these were meals people planned to eat or to record what they had eaten.

We recommend the provider reviews guidance about best practice in and application of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Requires improvement

Is the service caring?

Our findings

People were able to do some things for themselves but were not encouraged to be as independent as they could be. Staff were caring but they often did things for people rather than offering support to enable the person to try to do some things for themselves. For example, three people's care records confirmed they were able to help prepare meals but we did not see people do this during our visits to the home. Staff prepared and cooked meals and snacks. One person was able to walk around the home. Although there appeared to be a moderate risk of them falling, this was reduced as long as staff were able to support them. We saw on more than one occasion staff encouraged this person to sit down rather than to encourage and respect their wish to walk. Their parent told us they had become "More mobile" due to their physiotherapy programme and they "Really like to walk, but staff do need to help just to keep an eye on them" as they were at risk of falls.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's parents praised the way staff cared for their family member. One parent said "At the moment we are quite happy with the care. The staff we know are all lovely, caring people." Most people looked happy and settled, although one person was particularly distressed on both days of our inspection. They had been unsettled for some time and plans were in place for them to move to a more appropriate service. People responded to us in mainly non-verbal ways, such as smiling, laughing and vocalising.

People were involved in planning their care as far as they were able to. People's parents were also consulted. When people did not have relatives or others close to them to support them they had access to an advocate.

We observed kind and friendly interactions between people and staff. One staff member said "We are passionate about meeting people's needs." We saw that some people interacted with each other; there was a calm and homely atmosphere. Staff spoke with people in a polite, patient and caring way and took notice of how people responded to them. Staff treated people with respect. They spoke with people about the day's routines. People were asked on both days of the inspection what they wanted to do and chose how to spend their time.

Longer standing permanent staff had built close, trusting relationships with people over time. This had helped to ensure people received the care they needed and created a stable, homely and relaxed atmosphere. One parent said "It does take a long time to get to know [their family member]. Staff who have been there for a while know people really well. Some staff have changed recently and [their family member] does not really like change."

Staff were clear that they needed to get to know people well to provide good care. People had complex needs and communication difficulties. Staff told us they worked hard to provide good care but there were vacancies in the staff team and other staff were on long term sick leave. Relief and agency staff were used to cover shifts; the same temporary staff were used where possible. The staff rotas showed that both planned staffing levels and consistency in staffing were not always achieved. One staff member summed this up by saying "The team is depleted so the atmosphere here varies. Sometimes it's a bit manic, very stressed if we are short staffed or have agency staff who don't know people. I think we are on a bit of a low." Both the acting manager and the network manager accepted the staff team had been depleted. Experienced staff from some of the provider's other services had been brought in to help with this.

People were supported to maintain their privacy. Each person had their own room so they could spend time alone when they wished to. Some bedrooms had en-suite bathroom facilities. This helped to maintain people's privacy and dignity as each person required support with their personal care. Staff always knocked on people's bedroom doors before they entered the room. Staff treated personal information in confidence; all records containing confidential information were kept securely. Staff generally did not discuss people's personal matters in front of others, but we did witness this on one occasion. This was fed back to the network manager .

People were supported to maintain relationships with the people who were important to them, such as their parents. People were encouraged to visit as often as they wished and staff supported some people to visit their relations on a regular basis. One parent said "We go to visit every week and [their family member] comes to us every Sunday. It is always good when we are there. Staff always make you very welcome."

Requires improvement

Is the service responsive?

Our findings

People's support varied, although they had one to one staffing at times. People were able to plan their day with staff. Some activities were pre planned whilst others were more 'ad hoc'. On the first day of our inspection one person went to hydrotherapy. This was a regular, planned activity; additional staff were on duty to support this. People also spent time relaxing at home, in the garden or went into town with staff.

Records showed people went out, but the variety of activities was limited and staffing issues limited trips out. People went into town to use shops and cafes. One person visited their family every week. Another person had recently been on holiday. Staff had access to one vehicle to take most people out in; one person had their own vehicle. We noted that only two or three staff were able to drive the main vehicle and this limited its use and where people could choose to go.

Parents said their family members chose to do things which suited them. They told us people chose activities and outings they enjoyed although they felt people now went out less. Parents felt this could be due to staffing or staff changes. One parent said "They seem to have some fun. They take them out if they're well. They go shopping and go out on the bus sometimes. I don't think it's as much now though. Staff have left you see and I think some other staff we know are off sick."

Each member of staff told us that trips out of the home were limited. This was occasionally due to people's health issues but mostly it was due to staffing. Staff also said they wanted to support people to go out more to places they enjoyed and to support them to try new things. One staff member said "It's tricky with staff to get people out. People might only go out once a week but it can be a struggle even to do that some weeks." Another staff member said "We try to offer activities, but we are not so hot on choice. People are not going out every day, although they like going out."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four people's care records. People had detailed care plans, health plans and risk assessments. Plans included people's interests, likes and dislikes, communication and support needs. The plans for people did not consistently reflect the care provided. For example, people's preferred methods of communication were not used. People were not always supported to maintain their independence or pursue their interests and hobbies.

There was a complaints policy and procedure; an easy read version was also available. People would not be able to use the complaints procedure independently; they would rely on staff to help them or others to raise concerns or complaints on their behalf. Parents spoken with did not raise any concerns with us; they knew they could complain if they needed to and knew who to complain to. One parent said "If I was unhappy I would talk to staff. I've have complained once before but not for a long time." A recent complaint to the home was from a neighbour; there was no response recorded or any records about how it was investigated or what the outcome was. There were no recorded investigations or outcomes for either of the two previous complaints in 2014.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Parents felt permanent staff understood people's needs and adapted care and support if needs changed over time. This was often supported by health care professionals. One parent said their family member's mobility had improved "Due to the physio and swimming" and another told us their family member's health condition was "Controlled much better now as the GP had changed their medicines."

People's formal care reviews had not been carried out regularly; this was being addressed. These were an opportunity to review and adapt the care and support provided to people, ensure care records were up to date and that people received their planned care and support. They were generally attended by people's parents, a social worker, staff from the home and an advocate if appropriate. One person's review had been carried out on 29 May 2015; other reviews were now planned.

People participated in the assessment and planning of their care as much as they were able to. If they were unable to or chose not to this was respected. For example, one person had attended their recent review meeting and had contributed to it. Others close to them, such as their parents or other professionals involved in their care, were also consulted. One parent said "We do go to the reviews.

Requires improvement

Is the service responsive?

Usually the social worker will ring and ask us to go. We are going to the next one. We say what we think and I think they do listen. If we can't make any meetings, staff feedback to us."

Inadequate

Is the service well-led?

Our findings

The provider had not effectively monitored the quality and safety of the service or identified areas where improvements were required. The provider had an auditing system in place but audits had not been carried out when they should have been. Two separate audits should be carried out each month by the home's permanent or covering manager. These covered areas such as care plans, staff supervision, training, accident, incidents and health and safety; they were designed to identify any concerns or where the home was not meeting legal requirements. The records of these audits showed they were carried out until June 2014, then stopped, to resume in April 2015.

One of the provider's senior managers visited the home to evaluate the service based primarily on the information contained in the manager's two monthly audits. The provider's policy stated these visits should be carried out each month. The records of these evaluations showed they were carried out until July 2014, then stopped, to resume in March 2015. This meant there was no robust system in place to assess, monitor and improve the service or to ensure it met legal requirements.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had notified us of some significant events as required by law, but not all. The home had been subject to a safeguarding process led by the local authority during the early part of 2015 when health and social care professionals raised concerns about people's welfare and safety. This had not been reported to us.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The last registered manager left the home in September 2014; there had been a lack of consistent management and leadership since then. This meant there was no consistent member of staff to oversee the care and support provided to people. When staff were not supporting people in line with their needs this had not been addressed. For example, people were not communicated with using their preferred method. This lack of leadership had resulted in people not receiving consistently good care.

A new permanent manager had been recruited but had not worked at the home since December 2014. An experienced manager, who continued to manage one of the provider's other services, provided some support during January and February 2015. Then another of the provider's experienced managers worked at the home during February and March 2015. The current manager had been in post for four weeks; they would be applying to be registered with us. They were supported by four senior members of the team who led each shift and line managed a small number of care staff.

Regular meetings for both day and night staff should take place to allow staff to share information, discuss and resolve issues and plan improvements. They were also used by management to ensure consistent, high standards of care and support were provided to people. The provider confirmed staff meetings had been held in March 2014 (for day staff) and in April 2014 (for night staff) and then ceased until a full staff meeting in September 2014. The next staff meeting had then been held on 24 February 2015. This meant there was no regular formal way for staff to discuss the quality of care provided to people or other issues or concerns.

We read the aims of the service were to ensure people had choice, were involved in planning their care and providing support to enable people to meet their individual aim and aspirations. The aims were to be reinforced at staff supervisions, team meetings, through observation of staff practice and consistent leadership. Leadership, staff supervisions and team meetings had been inconsistent. One staff member said "It's been a stressful six months or so. Prior to that I think we were a really good team. It's knocked our confidence I think."

All staff spoken with had found the last few months very difficult and stressful at times. They told us that there had been many changes during this time, such as people moving out of the home due to refurbishment, staff shortages and one person's delayed move to another service, which had added to their workload. There was no deputy manager post, so there was no staff member in place to take on the managerial role which would have provided some continuity and stability. One member of staff summed it up by saying "It's been a bit chaotic really. The support leaders have been running the house with different managers popping in and out. Not having a permanent manager is stressful. We've really just tried to cope as best we can. I think we've done quite well but we are not managers."

Inadequate

Is the service well-led?

A meeting took place in February 2015, to discuss concerns which had been raised about the service by visiting health and social care professionals. This showed significant concerns in respect of the overall service and some specific concerns relating to individuals. These concerns mirror many of our concerns at this latest inspection. For example, concerns raised included medicine management, staffing and staff practice, poor interaction between people and staff, not following professional's advice, poor care planning and poor leadership. The provider had developed an action plan to address the concerns which was being worked through. However, the lack of consistent leadership at the home had impacted on this work and the anticipated timescales.

People were not easily able to share their views on the service; they could show their satisfaction in how they responded to the care and support being provided, for example by using non verbal communication. Some people had a close relationship with their parents who could be consulted, although there was no formal survey or other formal ways of gathering their views unless people chose to complete a feedback card. One parent said "They don't really ask us if we are happy with things in that way. They tell us what we ask and we go to reviews. They don't really ask you generally. Also we don't see other parents either except at events at the home like someone's birthday party so we don't know what they think."

People's parents were generally happy with the service but they were not clear who the manager was. One parent told us "In general we are happy, but there have been lots of changes over the last year. You do worry about that as a parent because the people there are so reliant on staff. Staff have to know them really well. I have no idea who the manager is now either. The manager has changed so many times since [the last registered manager] left."

The home had good links with health and social care professionals. A close working relationship had been built with the local team who supported people with learning difficulties. This enabled people to access specialist support to meet their needs and staff to access guidance on current best practice.

Jasmine was a well established part of the local community; it was situated close to the town centre. People were supported to use community facilities, such as local shops and cafes. People went into town with staff during our inspection. At times concerns or complaints were received from neighbours regarding noise levels at the home. However, these were not responded to effectively and could affect the home's ability to maintain good relationships with the local community.

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	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was failing to ensure the proper and safe management of medicines.** **Regulation 12(2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider was failing to ensure people were treated with dignity and respect. Staff did not use the most suitable means of communication for each person or respect each person's right to engage in communication.** **Regulation 10(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider was failing to ensure staff were provided with appropriate ongoing and periodic supervision and appraisal to make sure competence is maintained.** **Regulation 18(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider was failing to ensure people were supported to maintain their independence and autonomy in line with their needs.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The provider was failing to ensure people were involved in their community as much as they wished and had not ensured people were not left unnecessarily isolated. Regulation 10(2)(b)
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was failing to ensure people's care met their needs and reflected their preferences. Regulation 9(1)
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider was failing to ensure that complaints were investigated and proportionate action was taken. The provider was failing to ensure there was an effective and accessible system for dealing with complaints. Regulation 16 (1)(2)
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider was failing to ensure that they had notified us of all significant events as required by law. Regulation 18(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 The provider was failing to ensure that there was a robust system in place to assess, monitor and improve the service or to ensure it met legal requirements. Regulation 17(2)(a)

The enforcement action we took:
We issued a Warning Notice to the provider. This must be complied with by 11 November 2015.