Mr Adrian Lyttle

Mr Adrian Lyttle - Erdington

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 May 2017. This was an unannounced inspection.

At the last inspection in August 2016 the provider was rated as requires improvement in three out of the five areas we inspected against; whether the service was safe, effective and well- led. This was because the registered manager had not always fulfilled the responsibilities of their role by ensuring that the service was safe and effective for people living at the home. The registered manager had failed to implement safe recruitment processes and had not identified potential safeguarding concerns in order to protect people from the risk of abuse and avoidable harm. They had also failed to share information with us that they are required to notify us of, by law.

During this inspection, we found that some improvements had been made; however further improvements were required.

The home provides accommodation and personal care for up to 10 people who require specialist support relating to their learning and physical disabilities. At the time of our inspection, there were 10 people living at the home.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was not a registered manager in post at the time of our inspection. The person who was registered to manage the service had recently left. The provider had arranged for a member of staff to deputise and manage the day to day running of the service in the absence of a registered manager. Arrangements were also being made for the registered manager of the provider's other home in Sutton Coldfield, to apply for their registration with us to manage the service.

The service was not consistently safe, responsive or well-led because the management team had not always fulfilled the responsibilities of their role. The provider's quality assurance systems had failed to identify the shortfalls found during the inspection and some of the improvements required at the time of our last inspection had not been made.

Accidents and/or incidents were not always recognised as potential safeguarding concerns and key processes had not been followed. The provider had also failed to ensure that there were sufficient staffing levels to support people to live active and fulfilling lives, particularly at evenings and weekends.

Relatives did not always feel involved in the planning or review of the care that was being provided to their loved ones. Relatives were concerned that staff did not always have sufficient information in order to keep people safe from the risks associated with their physical healthcare needs. The provider had not ensured that all of the information that was pertinent to people's health and safety was readily available to new

and/or temporary members of staff, such as person-centred care plans relating to their physical health needs, allergies or personal emergency evacuation plans. However, the acting manager was responsive to our feedback and improvements have been made since our inspection site visit.

People received care and support with their consent where possible and were offered choices on a daily basis which included meal preferences. This meant that people had food that they enjoyed and any risks associated with their diet were identified and managed safely within the home.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary.

People received care from staff who had the knowledge and skills they required to do their jobs. People were supported to have their medicines when they required them, from staff who had the relevant knowledge and skills they needed in order to promote safe medication management.

The service was caring because people were supported by staff that were helpful and caring. Staff had taken the time to get to know people including their personal histories, likes and dislikes. People were also cared for by staff that protected their privacy and dignity and respected them as individuals.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible. People felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were supported to engage in some activities that were meaningful to them within the home and to maintain positive relationships with their friends and relatives.

Staff worked as part of a team and supported each other within their work. Changes to the management team meant that staff were experiencing a period of adjustment but reported the new manager's to be approachable in their leadership style.

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 always safe.

People were not always protected from the risk of abuse and avoidable harm. The manager had failed to identify when an accident or incident should have been raised as safeguarding concern with the local authority.

People were not always protected from risks associated with their care needs because risk assessments and management plans were not always specific to their individual care needs.

People were not always supported by sufficient numbers of staff in order to live active and fulfilling lives.

People received their prescribed medicines as required.

Is the service effective?

Good

The service was effective

People's rights were protected because key processes had been followed to ensure that people were not unlawfully restricted.

People received care and support with their consent, where possible.

People received care from staff who had received adequate training and had the knowledge and skills they required to do their job effectively.

People's dietary needs were assessed and monitored to identify any risks associated with their diet and fluid requirements and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff that were helpful and caring.

People received the care they wanted based on their personal preferences and dislikes because staff spent time getting to know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People felt involved in the planning and review of their care because staff communicated with them in ways they could understand. However, people did not always have the support of their relatives during this process because the provider had not always informed or involved people's relatives.

People were actively encouraged and supported to engage in activities that were meaningful to them within the home but had limited access to social activities outside of the home.

People were supported to maintain positive relationships with their friends and family.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was not a registered manager in post at the time of our inspection.

The management team had some systems in place to assess and monitor the quality and safety of the service. However, these were not always effective in identifying shortfalls found during the inspection.

Changes to the management team meant that staff were experiencing a period of adjustment but they reported the new manager's to be approachable in their leadership style.

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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 unannounced inspection took place on 4 May 2017. The inspection was conducted by one inspector.

As part of the inspection we looked at the information that we hold about the service. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also requested feedback from the local authority with their views about the service provided to people at Mr Adrian Lyttle Erdington. A Provider Information Return (PIR) request had not been sent to the provider prior to the inspection and therefore was not available to inform the inspection plans. This was because the inspection had been brought forward due to concerns we had received about staffing levels within the home. A PIR is a pre-inspection questionnaire that we send to providers to help us to plan our inspection. It asks providers to give us some key information about the service, what the service does well and any improvements they plan to make.

During our inspection, we spoke or spent time with six of the people who lived at the home. We also spoke with or received information from three relatives and four members of staff including the deputy manager, the acting operational manager and two carers. We reviewed the care records of two people to see how their care was planned and looked at the medicine administration processes. We looked at training records for all staff and at two staff files to check the provider's recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that people were not always protected from the risk of abuse and avoidable harm because the provider had failed to notify the local authority of a potential safeguarding alert. During this inspection, we found that some improvements had been made, but further improvements were required.

Information we held about the service showed us that the previous manager had reported a potential safeguarding concern to the local authority and that this had been investigated formally, as per policy and procedure. However, from reviewing the provider's accident and incident records, we identified an additional incident that should have been referred to the local authority in accordance with safeguarding procedures. The incident involved an altercation between two people who lived at the home. Records showed that staff had de-escalated the situation and there was no evidence to suggest that either of the two people involved had experienced any lasting ill effects or physical harm. Nevertheless, the acting manager acknowledged that this should have been reported to the local authority as a safeguarding concern. They explained that this was an oversight by the previous manager and they would ensure that improvements were made in this area.

People and relatives we spoke with were confident that people were protected against the risk of abuse. A relative we spoke with said, "I think they [people] are safe in that respect [referring to abuse]". We found that staff had received training on what action to take to keep people safe from the risk of abuse and avoidable harm. Staff we spoke with were aware of the different types of abuse and were able to explain what the reporting procedures were. One member of staff told us, "We have safeguarding training which covers the different types of abuse like financial, neglect, physical… and it tells us what to look out for like bruising, or if a person seemed withdrawn or not their usual self; I'd report it straight away to the manager and record it". This meant that staff had the knowledge and the skills they required to identify the potential risk of abuse and knew what action to take, but this was not always followed up by the management team.

Since our last inspection, we found that the provider had increased the staffing levels at night to reflect the changing needs of people living at the home. Whilst everyone we spoke with were positive about this change, staff and relatives were concerned that there were not always enough members of staff available during the day. One relative said, "There have been lots of cut backs which means there are only two members of staff on duty at any one time and it's just not enough; people don't get to go out or do anything because there is not enough staff". Another relative said, "Some people living at the home require two to one support; so what happens to the other nine people when staff are attending to them? It's not safe".

Staff we spoke with told us that there was currently a shortage of staff due to recent staff departures or staff sickness. One member of staff said, "It is very pressured at the moment; a difficult time for all of us. We are doing our best but we are short staffed and it is taking its toll". Another member of staff said, "There are only two of us on [duty] in the mornings and in the afternoon/evenings. I don't think that is enough for ten residents [people] especially when a couple of them need two members of staff to support them". We found that during the hours of 9:00 and 15:30, Monday to Friday, eight of the people living at the home attended

day care services and one other person attended adult education services, on two days a week. Therefore two members of staff was deemed sufficient to provide care for the one to two people who remained at the home during the weekdays. However, when all ten people returned to the home after 15:30 on weekdays and throughout the weekends, two members of staff was not enough to ensure people received the care and support they required in order to live fulfilling lives. The acting manager acknowledged our feedback. Since our inspection, we have received information from the provider telling us that they have reviewed the staffing levels and planned to increase staff deployment in the afternoons as soon as reasonably possible.

The provider also told us that there was an on-going recruitment drive to address the issues raised concerning staff shortages. Records we looked at confirmed that the provider had recently recruited two new members of staff to support the increased staffing levels at night and they were actively recruiting to fulfil staff shortages during the daytime. At our last inspection, we found that the provider's recruitment systems and processes had not always been followed to ensure that people were protected against the risk of unsuitable staff being employed to provide care to them. During this inspection, we found that since the new management structure had been introduced, the provider's recruitment processes had been implemented effectively. The acting manager explained, "We check all staffs' identification documents and make sure references match their employment history and they are of good character". They went on to say, "All new staff are required to complete an induction programme, including shadowing existing staff members to get to know people before they begin to work unsupervised. This is in addition to a probation period, whereby they are essentially interviewed by the people that live here; we soon know if the residents like or dislike new staff from how they react around them and things they say to us; this is how we involve our service users in the recruitment process".

Whilst the provider continued to actively recruit to staff vacancies, as an interim measure, they had introduced the use of agency staff to cover any outstanding day time shifts. They told us that this was deployed to relieve some of the pressures on permanent members of staff. Relatives and staff we spoke with were confident that the agency staff were skilled and experienced in their work. However, they were not always assured that the agency staff or new members of staff were familiar with peoples individual care needs and any associated risks. A relative we spoke with said, "I am not sure all of the staff know the people they are caring for very well, like allergies or how to know when someone is physically unwell if they can't tell you themselves; I have been told that they don't always get a handover when they come on shift". Another relative said, "They don't seem to recognise when [person] is unwell or pick up on things they should do anymore; it does really worry me".

Staff we spoke with told us and the acting manager confirmed that handover's took place but that these were not documented. We were also told by staff that previously this was not a concern because all of the staff that worked at the home were regular members of staff who knew people well. However, since new members of staff had been recruited and the introduction of agency staff, they could not be assured that information regarding people's individual care needs and any associated risks, were readily available or communicated to staff effectively. One member of staff said, "All handovers are verbal, it is not recorded. All staff have access to people's care files to get information they need about risks but whether they do or not, I don't know. It would be useful to have a handover sheet with a summary of each person which included the most important information, and they could then add to it based on the handover they get as well". We fed this back to the acting manager and since our visit we have received information to say they are 'looking in to completing a staff handover sheet'.

Staff we spoke with were able to tell us about how they would recognise if a person was physically unwell or were experiencing pain and they knew what action they needed to take in an emergency. For example, one member of staff told us, "[person's name] can't tell us verbally if they feel unwell or if they are in pain, but we

can see from their facial expressions or body language if something isn't right". Another member of staff said, "Some people can't tell us if they are feeling unwell, but if we notice that they don't seem themselves and we ask them directly if they are in pain, most are able to point to where hurts, but for others, we have to just use our judgement based on how well we know them and act in their best interests". However, records we looked at did not include any information that was specific to people's physical health needs or any person-centred information that detailed how staff could recognise if a person was feeling unwell or experiencing pain. This meant that new or agency staff, who did not know people well enough to identify signs and symptoms independently, did not have the information they required to ensure they were meeting people's needs safely and effectively. We fed this back to the acting manager. Since our visit, we have received evidence to show that the provider has now introduced person-centred care plans relating to people's physical health needs.

At our last inspection, we noted that risk assessments were largely generic and related to risks around the home, such as health and safety within the different rooms of the house. Whilst no impact on people was identified at the time of our last inspection, due to the consistency of staff and how well the staff knew people, this could not be evidenced on this inspection.

We found that improvements had not been made and there continued to be no evidence that person-centred risk assessments had been implemented. This was a concern considering the provider had recently recruited new members of staff and was more reliant on agency staff. Therefore, this information would be pertinent in ensuring that staff had the information they required to enable them to keep people safe. We fed this back to the acting manager at the time of our inspection. We have since received confirmation from the provider that these have been implemented to promote the safety of people living at the home.

People we spoke with told us that they were happy with the care they received at the home and that they felt safe. One person we spoke with told us, "They [staff] help us [people] and look after us. We are safe". Another person we spoke with said, "I like living here. Staff look after me and keep me safe". Throughout the inspection we saw that people looked relaxed and comfortable in the presence of staff. We saw that staff acted in an appropriate manner to keep people safe. For example, we saw that one person needed support to walk to the dining room; staff provided support and reassurance to the person to give them the confidence to walk to the dining room to join their friends for a meal.

We were told that all of the people living at the home required support to take their medicines and that all of the staff were trained to administered medicines. One person we spoke with said, "They [staff] give me my medicines when I need it and look after it for me". A member of staff we spoke with told us, "We are all very meticulous about making sure medication is done properly". Records we looked at showed that people had received their medicines as prescribed. Where people were prescribed medicines on an 'as and when required basis' (PRN), protocols were in place to support staff to administer these safely and effectively. We saw that medicines were stored appropriately and staff were aware of the disposal policy for unwanted or refused medication. Processes were in place to identify missed medication promptly and there was a good rapport between the provider, GP's and the local pharmacy to ensure people received their medicines as prescribed.

Good

Is the service effective?

Our findings

Everyone we spoke with, observations we made and records we looked at showed that staff had the knowledge and skills they required to do their job. One person told us, "They [staff] are good at their jobs; they look after us well". A relative we spoke with said, "Most of the staff are very good, there's just not enough of them". One member of staff we spoke with said, "We do a lot of training and each month we do refresher training on different topics, so we cover everything on a yearly basis". We saw that the acting manager kept a training record which detailed the dates when staff had completed various training as well as a rolling programme of updates that staff were required to undertake throughout the year. This meant that the acting manager knew when staff were due any refresher or additional training and ensured that this was facilitated. This ensured that people received care from staff who had the knowledge and skills they required to do their jobs safely and effectively.

Staff we spoke with told us and records we looked at showed, that staff received supervision from the acting manager to discuss any training needs or concerns. This allowed the manager to further monitor the effectiveness of the training and how staff were implementing their learning in practice. We were also told by staff and records showed that the manager facilitated regular team meetings to discuss any outstanding training or service-related issues. One member of staff told us, "We have supervision; since the changes in management, this hasn't been as regular but I know [deputy manager] is arranging them now; we also have team meetings every month; again, these need to be arranged by [deputy manager]".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that staff were able to tell us about people's capacity to consent to the care that they were receiving and that people were being cared for in the least restrictive ways possible. Where people were deemed to lack the mental capacity to consent, applications to deprive the person of their liberty within their best interests had been sent and authorised. The acting manager showed us confirmation that they had received from the local authority, whilst they were awaiting the authorisation documentation.

People we spoke with told us and observations we made showed, that staff gained consent before providing care to people, offered people choices about the help and support they required and gave a verbal dialogue about what it was they were going to do to help the person. One person said, "Staff help us and ask us what we need" and "They listen to us". Staff we spoke with were able to give examples of how they promoted consent and independence as much as reasonably possible, in all aspects of the day to day care and support they provided to people. One member of staff told us, "We always talk to them [people] and give

them a choice, so its [care] is their decision". Another member of staff said, "Some people can't tell us what they want but we can offer choices in other ways, like pointing to things".

People we spoke with told us that they had a good choice about what they ate and they enjoyed the food the staff prepared for them. One person told us, "I have my favourite food here; tonight is sausage and mash!" Another person said, "Staff ask us what we would like, it's always nice". Staff we spoke with told us that they prepared all of the meals at the home and where possible, they encouraged people to get involved in some of the meal preparation in order to promote their independence. One member of staff told us, "We [staff] do all the cooking, but some people are able to do sandwiches and cold drinks with our support". On the day of our inspection we saw people helping in the kitchen and laying the tables.

We found that people had access to doctors and other health and social care professionals as required. One person said, "They [staff] take me to my appointments". A relative we spoke with said, "They [staff] will take her to appointments, but they don't always feed back to me. Sometimes, if they are short staffed, they ask me to go". Records we looked at confirmed that people were supported to maintain good health and to attend any medical appointments they were sent including those relating to their learning disabilities. We also saw that the provider had ensured people had access to specialist learning disability services and any health care concerns were followed up in a timely manner with referrals to the relevant services.

Good

Is the service caring?

Our findings

People and relatives we spoke with were consistently positive about the caring attitude of the care staff and the relationships that were formed between them. One person we spoke with told us, "They [staff] are all nice but [care assistant's name] is my favourite; she is my key worker and helps me a lot". Another person said, "They [staff] help us with anything we need; we are all friends here and its nice being here; we give each other hugs". A third person said, "I like it here, I am happy; staff are nice". A relative we spoke with told us, "The care staff are always polite and very nice, but of course, a lot of them have changed now, so I hope the new staff are just as good". Another relative we spoke with said, "The care staff are nice enough and friendly but there's just not enough of them".

Staff interacted with people with warmth, compassion and familiarity. We saw that staff adapted their communication and interaction skills in accordance to the needs of individual people. For example, one person was able to understand verbal prompts, whereas another person responded to physical prompts and gestures. We saw staff were responsive to people's need for reassurance and used therapeutic touch appropriately. It was clear that people had developed trusting relationships with the staff that were providing care to them on the day of our visit.

People we spoke with told us that staff took the time to get to know them and staff understood their histories, likes, and preferences. One person said, "They [staff] know what I like". Another person told us, "We have key workers, who work with us, they know us really well and help us a lot". Staff we spoke with were able to tell us about different people's individual care needs. For example, one member of staff we spoke with was able to tell us what level of support each individual person required and provided us with examples of people's interests and how they liked to spend their time. They said, "[person's name] is very independent and likes to get out and about, while [another person's name] is much quieter and needs a bit more support from us to get involved; they all have their own personalities and we support them all in different ways". Care records we looked at included information about people's life histories, daily routines, preferences, hobbies and interests. We saw that some people had a particular interest in the Special Olympics and others liked watching DVD's and going bowling. This was confirmed when we spoke with people and staff.

Everyone we spoke with told us and we saw that staff treated people with dignity and respect. One person said, "I do lots for myself but the staff check on me to make sure I am ok [during personal care]". A relative we spoke with said, "[Person's name] always looks presentable". Staff we spoke with told us it was important to respect people as individuals and that they promoted people's privacy and dignity at all times. One member of staff said, "We [staff] always knock before we enter rooms". Another member of staff told us, "Some people need support in the bathroom; we help them as much as they need us to and then stand back to give them some privacy and encourage them to be independent". However, relatives we spoke with were concerned that staff were not always supporting people as much as they needed. One relative said, "They [staff] tell me that they have to promote their [people's] independence, but sometimes I think they take this too far". They gave an example of how one person was experiencing repeated 'rashes' and it was because staff were not making sure they had dried themselves properly after having a shower. Another relative said, "When I raise something with them [management] they tell me that they can only encourage

[person's name] to do something, they can't make them; but I think they are being paid to care for them and they should sometimes be acting in their best interests because they [people] don't always know what they want or need". We fed this back to the acting manager. They told us that they would discuss these concerns with people and their relatives during care reviews to ensure that they were meeting people's individual needs and expectations.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us that they were allocated 'key workers' who supported them to plan and review their care in a way that was personalised to them. One person said, "We [people] meet with our key workers and go through our care plans". However, relatives we spoke with told us that they were rarely consulted or updated on any care related issues. One relative said, "I have had to ask for a copy of [person's name] care plan as I don't know anything anymore. Now I have asked I have been invited to a care review". Another relative said, "I am involved but only because I get involved; otherwise I wouldn't be updated on anything". This meant that people who were unable to tell staff what they wanted or needed, were not always given the opportunity to have an representative, such as a relative, involved in the planning or review of their care. We discussed this with the acting manager. They explained
that the new management team were aware of the need to engage with and involve relatives more (where required) and that this was something that they intended to work on as a matter of priority. They said, "Unfortunately, we have found that the constructive feedback that you have received [from relatives] may have been building up for some time. We are working with families and relatives to try and overcome these areas and will keep them informed with any changes that we will be making; hopefully with time families and relatives will be happy with all outcomes".

People we spoke with and records we looked at, showed that the provider asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One person told us, "We have meetings together with the staff where they ask us about things, like if we are happy". Another person said, "We all sit in the lounge and talk about important things like where we would like to go on holiday". A relative said, "We get to give feedback about once a year when they send out the surveys but that's about it now; we aren't otherwise asked to pass comment on anything unless we make it our business to; it's gone downhill". Another relative said, "I do let them know what I think, but nothing very often changes anymore; it seems to be brushed under the carpet". At our last inspection we saw that the provider had used the feedback that they had received from people, relatives, staff and visiting professionals to produce an annual report, which determined any improvements that were required. The acting manager explained that they were currently in the process of sending out surveys in order to maintain this process but also planned to make improvements to the frequency and the way in which feedback was sought. We will monitor the outcome of these improvements at our next inspection.

Everyone we spoke with told us they knew how to complain. One person told us, "If I had a problem I would tell the staff". Another person said, "[deputy manager's name] is the boss now so I would speak to him". Records we looked at showed that the provider had a complaints procedure in place. The acting manager told us and records we looked at, showed that they had not received any formal complaints. They said, "We try to deal with things before it gets as far as a complaint". However, feedback we had received from relatives did not always support their statement. For example, a relative we spoke with said, "I had a good relationship with [previous registered manager] so things are a little different now. I have spoken with [deputy manager] and it doesn't always feel like he is listening, but we will see, time will tell". Another relative told us, "I can speak to the manager and I have even asked to speak to the owner [provider] before now; he deals with things in his own way, but they [new management] are quite laid back about things it

seems, I'm hoping it will get better". The acting manager acknowledged that improvements were required to the way in which they recorded and dealt with any constructive feedback they received including complaints.

We saw people engaging in activities that they enjoyed. For example, we saw people going out to day centres, visiting family independently and spending time relaxing in their bedrooms watching television. One person told us that they enjoyed watching DVD's and took the time to show us their DVD collection. Another person told us they enjoyed going out with their friends for coffee and that staff would support them to do this. However, they told us that this had not happened for a while. We found that people were actively encouraged and supported to follow their own interests, such as the Special Olympics and to engage in adult education courses. People we spoke with also told us that they were looking forward to going on holiday in June and again in September. They were particularly excited this year as they were going to St Ives which was somewhere they had not been before and they were looking forward to the ice cream. Everyone we spoke with also told us that their friends and relatives were always welcome to visit them and they were able to spend time with people who were important to them.

However, people, staff and relatives that we spoke with all felt that there were not always enough members of staff in the afternoons/evenings or weekends to support people to engage in meaningful activities outside of the home. One person said, "I like to go to the theatre; staff can't take me but I go with my family sometimes". A relative we spoke with said, "They [people] used to do a lot and their lives were active and fulfilling, but not anymore. They [people] never get to go anywhere or do anything now because there's not enough staff. Ok, they go on holiday twice a year, but what about evenings and weekends? They could go bowling, or to the cinema, or maybe out for a meal but they don't do anything because there's only ever two members of staff. It's not good enough, they are young adults". A member of staff we spoke with said, "We'd love to go out with people, even if it's just for a coffee and a bit of shopping with the girls, they'd love that, but we can't because if one member of staff goes out, that only leaves one in the house and that's not safe". Another member of staff said, "They [people] would love to go out and do more but we just don't have the manpower; there's not enough staff". We discussed this with the acting manager at the time of our inspection. They told us that they did not have an activity schedule because people's activities were recorded in their individual files based on what they do during the week. They acknowledged that the provider did not arrange any structured group activities or community outings but that this was something they planned to improve. They said, "We are recruiting an additional member of staff to assist residents to access the community and participate in further activities".

We saw that people were supported to express their individuality and staff were aware of how they could promote equality and diversity within the home. One person we spoke with said, "My favourite colour is purple and I love butterflies". They showed us their bedroom and we saw it was painted purple with lots of pictures and wall decorations of butterflies. They said, "I chose all of these [pictures and decorations] myself". A staff member we spoke with said, "People have their own interests and we encourage them to make their own choices about things that reflects their personalities". We found that people were referred to by their preferred names, their independence was promoted as much as possible and they were able to express themselves as individuals. For example, we explored thoughts, attitudes and practices around sexuality within the home. We found that people were supported to have relationships and staff respected the diversity of people's sexuality within the home. One member of staff said, "We do have two couples in the home who refer to each other as boyfriend and girlfriend and we support them to engage in this relationship in a way that promotes their privacy, dignity but also their safety". They told us that one person living at the home shows an interest in people of both genders and that whilst they do not discourage this, they have to explain to the person, that not all people reciprocate relations from people of the same or opposite sex. The member of staff said, "We are very open here and it is very diverse in many ways, gender,

age, race, religion and sexuality".

Requires Improvement

Is the service well-led?

Our findings

The provider was required to have a registered manager in place as part of the conditions of their registration. There was not a registered manager in post at the time of our inspection. However, the provider had arranged for a member of staff to deputise within the management role on a day to day basis. They also had plans for the registered manager of one of their other homes, to oversee the operational management of the service and apply for their registration with us.

At the time of our last inspection, we found that the provider had not always ensured that information that they were legally required to share with us and other external organisations, such as the local authority, was passed on. We also found that the quality assurance processes and systems had failed to recognise the shortfalls that we had identified during the inspection. Whilst, there was no evidence that these omissions had negatively impacted upon the safety of people using the service, the registered manager at that time, acknowledged that improvements were required. However, during this inspection, we found that not all of the improvements that we identified at the time of our last inspection had been made and further improvements were required. The acting manager acknowledged this and stated, "Since taking over [management of the service] we can now see that things have been on a steady decline and some of the things that should have been done since the last inspection, have not been completed. However, I can assure you that the new management structure will work hard to ensure improvements are made".

We saw that there were some systems in place to monitor the quality and safety of the service and that some of these had been used effectively. These included audits of the environment, maintenance checks, and medication processes. However, not all of the quality monitoring systems and processes were effective. For example, they had failed to recognise that areas that had been identified as requires improvement at the time of our last inspection had not been addressed. They had also failed to recognise the deterioration of relations between the management and people's relatives and other representatives. The need for enhanced staffing levels, improved care planning and risk management plans as well as the lack of opportunity for people to engage in activities outside of the home had also been missed.

Since our inspection, we have received evidence from the provider to demonstrate that they had started to implement changes to some of the areas we had identified as shortfalls, in response to the feedback we provided to them throughout the inspection process. For example, the provider acknowledged the need for additional staff during the afternoon/evenings and weekends and has put plans in place to recruit staff to fulfil this shortfall. We have also seen evidence to show that the provider has started to introduce care plans that are more specific to people's needs. These include their mental capacity to consent to the care they are receiving and any associated deprivation of liberty safeguards needs, as well as their physical health needs. The latter document includes details of the signs and symptoms each individual may display to indicate that they are unwell or in pain. It also details what action staff should take in order to meet their needs at such times. The provider has also introduced a daily summary report sheet for each individual person which will be used to inform the handover from one staff member to another. This is intended to support new and/or agency staff members as well as regular members of staff to ensure they have a better understanding of people's individual care and health related needs and any associated risks. A personal emergency

evacuation plan has also been introduced in order to further promote the safety of people living at the home in the event of a fire and the provider has arranged for the local fire service to support them in completing these effectively.

Staff we spoke with told us they felt supported within their work because they supported each other and worked as part of a team. One member of staff said, "I love my job and I love the people I work with; I can't fault any of them". Another member of staff said, "We [staff] are all doing our best in a difficult situation, we are pulling together and putting the residents needs first; but something needs to give". We were told that the changes in management and the reduced staffing levels had had an impact on staff moral within home. Staff we spoke with confirmed that the acting manager and the deputy manager were approachable, but their leadership style was different to the previous manager and would take some time for them to adjust to. One member of staff said, "[previous registered manager's name] was always around if we needed him and very hands on, whereas [deputy manager and acting manager] expect a lot more from us despite us already being short staffed and communication isn't always as good, we aren't kept informed as much, but hopefully it will improve; we know they are under a lot of pressure at the moment too and are addressing things one at time". Another member of staff said, "Obviously, I would have felt much more comfortable speaking with [previous manager] because I knew him better, but I think they [acting manager and deputy manager] are approachable". A relative we spoke with told us, "A lot has changed over the years and this is just another change. I can't help but worry, it's getting worse with the cutbacks and I would have [person] home full time if I could". We discussed these concerns with the new management team at the time of our inspection. They agreed that there had been a lot of changes to the service recently and it had been a turbulent time for everyone, but they were confident that with the new management structure in place, things would start to improve. The acting manager said, "We have such a good staff team here. Our staff are excellent. They are reliable and they understand that this is a small, family run business that keeps the people we care for at the heart of all we do. They have really pulled together and supported us during this difficult time, much to their credit. We appreciate that it's not an ideal situation but we are doing all that we can to relieve some of the pressure by using agency staff and by actively recruiting". We were told that the new management team planned to work on re-building relations with relatives and improving the communication links between them and the staff. The acting manager went on to say, "We have staff meetings, supervisions and informal discussions with staff, we just need to make sure that this is a two-way process and not just about us delivering information as it may have been previously".

Staff we spoke with were aware of the provider's whistle-blowing policy. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved. One member of staff told us, "If I had any concerns I would go straight to [deputy manager's name] or [acting manager's name]; I could even go to [provider's name] but failing that if I wasn't happy with their response, or I was worried about them in particular I can go to yourselves [CQC]". Information we hold about the provider showed that we had received a whistle-blowing concern recently. We discussed these with the acting manager at the time of the related incident and also explored some of the concerns as part of our inspection process. We found that the provider had started to address some of the concerns prior to our inspection and further improvements were being implemented following our feedback. We will continue to monitor the provider's compliance in accordance with the conditions of their registration and will check the progress at our next inspection.