Lester Hall Apartments Limited

Lester Hall Apartments

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection visit was carried out on 28 June 2018 and was unannounced.

At the last comprehensive inspection in February 2017 the service was rated as Good.

Lester Hall Apartments is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service cares for people with mental health needs. At the time of our inspection there were 30 people using the service.

There were two registered managers in post who job shared. 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.

Systems and processes did not ensure the safe management of medicines and people could not be confident they were supported to take their medicines as prescribed.

There was a lack of systems to monitor the quality of the service and identify where improvements were needed to ensure people received safe, good care as a minimum.

Procedures for controlling the risk of infection were not embedded in staff working practices and were not effective in supporting the prevention of infection for people.

Where people were at risk of poor nutrition or dehydration, records were not completed accurately or correctly to show people had received nutrition and fluids in line with their assessed needs. People were positive about the quality and choice of meals provided.

Records did not reflect that all potential risks to people had been assessed appropriate, and did not include the detail and guidance regarding the measures staff needed to take to reduce risks. Staff demonstrated a good understanding of actions they needed to take to keep people safe.

Care plans were not always updated in a timely manner and records did not consistently provide the detail and information staff needed to meet people's needs. The registered manager was in the process of reviewing and updating care plans and records.

People were protected from the risk of unsuitable staff because the provider followed safe recruitment procedures. There were enough staff available to meet people's needs as assessed in their care plans.

Staff had completed a range of training to provide them with the knowledge and skills they needed to meet

people's needs. Training records were not maintained accurately or fully completed to support the effective analysis and monitoring of staff training.

People were supported to access a range of health professionals to maintain their health and well being. The service worked in partnership with other agencies to ensure people received the care and treatment they needed.

People's needs were assessed prior to them using the service. People were supported to make choices and decisions about their care. Staff understood the principles of the Mental Capacity Act 2005, sought consent before providing care and respected people's right to decline care and support.

People were treated with kindness, respect and compassion and were given emotional support when needed. Staff supported people to achieve as much independence as possible and protected people's right to privacy and dignity.

People and their relatives were involved in planning their care and were able to make changes to how their care was provided.

People had access to a range of varied activities and were supported to be involved in their local community. People maintained contact with their friends and family and were therefore not isolated from those people closest to them.

People understood how to raise concerns and complaints and were confident these would be listened to and acted on.

The registered manager and the registered provider promoted a culture that was focussed on personalised care. Staff supported the provider's values of enabling people to be as independent as possible and engaged in meaningful activities. People, relatives and staff were able to share their views about the service directly to the registered provider and these were used to develop the service.

We found breaches 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 report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements were needed to the management and administration of medicines to ensure people received their medicines safely and as prescribed.

Risk assessment records did not always include the detail and guidance staff needed to mitigate potential risks.

Systems and processes to manage the risk of infection were not robust and not consistently followed by staff.

Staff had an understanding of abuse and their responsibilities to act on concerns.

Staff were deployed in sufficient numbers to keep people safe and meet their needs in a timely manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were able to make choices and decisions about their life and staff had an understanding of the Mental Capacity Act 2005. Further improvements were needed to demonstrate how people's mental capacity was assessed and reviewed.

People were positive about the meals and drinks provided. Further improvements were needed to ensure records supported the effective monitoring of people's nutritional needs and protected people from the risk of poor nutrition.

Staff felt supported and skilled to provide effective care. Records did not always demonstrate staff had received the training they needed to meet people's needs.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in their care and

supported to make decisions and choices.

Staff understood the importance of maintaining people's independence where possible.

People's dignity was maintained and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always included the detailed guidance staff needed to meet people's needs. Records were not consistently reviewed in a timely manner to ensure they reflected people's current needs.

People were supported to pursue a range of hobbies and interests and chose how they spent their time.

People felt confident to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People could not be certain the quality of the service would be maintained because improvements that were needed to the service were not being identified.

People and relatives were positive about the culture and leadership of the service. People and staff were supported to share their views about the service.

Lester Hall Apartments

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.

The inspection was prompted in part by notification of two incidents during which two people using the service were placed at risk of harm. One of these incidents is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incidents indicated potential concerns about the management of risks for people using the service, particularly around the management of behaviours that may challenge. This inspection examined those risks.

This inspection visit took place on 28 June 2018 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we looked at information we held about the service, including notifications the provider had sent us. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also spoke with other agencies, including commissioners responsible for funding some of the people using the service, to gain their views about the care provided. Our review of this information enabled us to ensure we were aware of, and could address, any potential areas of concern.

During our inspection we spoke with three people and two relatives of people who used the service. We also spoke with the registered provider, the registered manager, the deputy manager, five care staff, the maintenance person, two office administrators, an activity co-ordinator and three visiting health professionals. We observed care and support provided in communal areas and the lunchtime meal. This helped us to evaluate the quality of interactions and support that took place between people and staff who supported them.

We reviewed information including care plans and records for four people, medicines records, four staff recruitment files and staff training records. We also looked at records relating to the day-to-day

management of the service and the provider's internal audits and quality management systems.

Following our inspection visit, we asked the registered manager to send us information regarding staff training. They sent this to us in at timely manner.

Requires Improvement

Is the service safe?

Our findings

Areas pertaining to the management and administration of medicines required improvement. Improvements had recently been made to ensure more secure storage of medicines. Temperatures of fridges used to store medicines was monitored and recorded. However, temperature checks of the storage area of other medicines were not in place. This is important to ensure medicines are being stored in line with manufacturer guidance to maintain the integrity of the medicines.

We sampled medicine administration records (MARs) for four people. These showed inconsistencies in codes used by staff whilst administering medicines. For example, staff were inconsistent when entering codes on MARs where people had declined their medicines. Some staff had used code 'A' indicating refusal, whilst others had used code 'N' for refusal which actually meant not required. This meant records had not been completed accurately to clearly indicate if people had declined their medicines.

We checked medicine stock records for four people. We found discrepancies in the records we sampled. For example, records showed one person should have had 72 tablets left in stock. However when we counted the medicines, we found there were 67 tablets in stock. A second person had an extra two tablets in stock, compared with amounts on stock records. These discrepancies could indicate potential errors in the administration of medicines, with people receiving too little or too much medicines.

Some people were prescribed medicines to be taken on an 'as and when required' basis [PRN}. We found these medicines were not always supported by a protocol to guide staff on when and how the medicines should be administered. This is particularly important for people who need staff support to recognise when they need these medicines, for instance, to manage pain or anxiety. Topical medicines, such as creams and lotions were not always supported by a body map. This is important to inform staff on the correct area or route of application.

Care plans included risk assessments for areas such as falls, mobility and risks associated with people's health conditions. In some cases, risk assessments did not provide the detail and guidance for staff on how to reduce the risk of harm for people. For example, one person required oxygen to manage their health condition. Their care plan did not include a risk assessment to guide staff on the safe management and use of this. A second person had been identified as being at risk through the way they stored and managed food. Although their risk assessment identified the measures staff needed to take to reduce risks, records lacked detail. For instance, records did not guide staff on risks through poor infection control and the impact of these on the person's health and wellbeing. The risk assessment did not advise staff on actions to take in the event the person did not consent to their monitoring or support to maintain a safe environment. When we met with the person in their room, we saw the kitchen area was dirty and cluttered with food left exposed on work surfaces. This meant that staff may not have the information and guidance they needed to enable them to respond and mitigate potential risks for people.

Risk assessments were not always in place for people who left the premises without staff supervision. This is important to identify potential risks for the person in the local community and identify measures to reduce

these risks. Two people smoked in their room. In one person's room we saw an armchair had several cigarette burns to the fabric. Risk assessments were not in place to mitigate potential risks to the person and others through smoking in their room.

People's risk assessments did not always provide enough guidance for staff to manage people's behaviour that challenged others. For example, records detailed potential triggers for behaviours and how behaviours presented for each person. However some records lacked the detailed guidance staff needed to intervene and respond to keep people safe. For instance, guidance for one person advised staff to 'diffuse and talk to me' when they became anxious and 'call the professionals in'. Records did not provide the detail of how staff should approach the person or at what point health professionals should be contacted. A second person's plan advised staff to approach the person 'in the correct manner and not make an issues of things. Try and diffuse and reassure.' It was not clear from records as to what the 'correct manner' was or what method of diffusion or reassurance should be followed. This meant that staff may not have the knowledge and information they needed to support people consistently when they became anxious, distressed or frustrated.

The failure to ensure the proper and safe management of medicines and lack of detailed risk assessments constitutes breaches of Regulation 12 (2) (b,g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

We found improvements were needed in day to day cleaning and management of infection. For example, some bathrooms required a deep clean to address dirty grouting, areas were cluttered and toilet bowls required re-sealing at bases. We found faecal matter on a shower chair in a bathroom which we raised with staff. We found two chairs in the dining area with ripped covers which required replacement. Other areas of the premises were clean and free from malodours.

Cleaning products were safely stored away and staff described following infection control procedures. However, we found two mops which should have been stored separately, stored together in the same bucket outside a cupboard. Cleaning audits were in place but were not descriptive. There was no checklist or schedules for staff to follow to ensure cleaning methods prevented the risk of infection for people. When we asked the deputy manager about the lack of cleaning schedules, they told us they assumed staff knew what they were doing.

The provider employed a maintenance service, which was overseen by a designated health and safety officer. Regular maintenance and equipment audits relating to fire safety records, maintenance of safety equipment, gas, portable appliance and electrical testing were undertaken. We recommended the health and safety officer reviewed water temperatures within people's rooms as some temperatures were recorded as being in excess of recommended safe levels.

People and relatives we spoke with told us they felt safe using the service. One person told us, "I feel safe because there is always staff around. They use the right equipment to help me move around and talk to me to ask how I am doing." Another person told us, "I do feel safe here. The staff don't let me get too low which helps to keep me safe. There are some people here who I stay away from as they can be verbally abusive." A relative told us they felt staff provided good, safe care for their family member.

Staff had attended safeguarding training to protect people from harm and abuse. Staff we spoke with knew how to recognise signs of abuse and how to report any concerns. Staff were also familiar with the term whistleblowing. This was a process for staff to raise concerns about potential malpractice at work. The provider had a policy regarding adult abuse in place. This required further development to ensure it clearly

referenced and explained safeguarding, including local agency guidance in reporting and referring potential safeguarding concerns. Safeguarding and whistleblowing information was available for people, staff and visitors on communal notice boards. This helped to support people's awareness of safeguarding and action to take if they had concerns.

People told us they felt there was enough staff around to meet their needs. We saw staff were attentive and people didn't have to wait long for assistance. Staff supported people to move around the premises safely where required. At least one staff member was always present in communal areas to provide appropriate supervision and support. Staffing rotas confirmed that the staffing levels we observed were maintained consistently.

People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures. Staff recruitment files included evidence of employment history, proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with people using care services and helps employers to make safer recruitment decisions.

The provider had recently made improvements to procedures for reporting and reviewing accidents and incidents in the service. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms identified the events leading up to the incident, behaviours and intervention and response. For example, where one person had left the building unsupervised, an extra locking device was to be fitted to the front door. Another person had experienced a fall which had not been witnessed and as a result a referral had been made to the falls clinic. Reviews included action plans in response to incidents and details of any external agencies who had been informed. Staff confirmed the provider had discussed recent incidents and supported staff to identify lessons to be learnt as a team.

Requires Improvement

Is the service effective?

Our findings

We looked at how people were supported to maintain their health and wellbeing. We saw where people were assessed as at risk of poor nutrition, weight monitoring charts were in place. Records we looked at did not support the effective monitoring of people's health. For example, weight monitoring charts had extensive gaps between recorded weights, spanning several months. In three care plans people had lost weight. There was no explanation for the gaps in records or if any action had been taken as a result of the person's weight loss. Monitoring charts did not include an ideal weight for people to guide staff on action to take if a person's weight changed significantly.

Care plans did not always include the guidance staff needed to support people to manage their health conditions. For example, one person lived with a health condition that required monitoring and timely staff intervention if their health deteriorated. Their care plan did not provide any guidance on symptoms the person may experience in the event their health declined, or suggested staff intervention and response to signs and symptoms to prevent the person reaching a health crisis.

Fluid and food intake charts had not been completed accurately or consistently. Records were disorganised and made it difficult to identify trends and patterns. Records had not been completed consistently. For example, records for one person were vague such as 'ate whole meal'. However, there was no indication of the portion size or what the person's target fluid and food intake was. Where fluid charts had been completed, these had not been totalled each day to identify if the person had consumed their target amount necessary to avoid the risk of dehydration. Health professionals we spoke with told us records did not provide the information they needed and did not indicate people's health needs were being met. The lack of information and effective monitoring meant people could be at risk of poor nutrition.

Other records in care plans demonstrated staff were proactive in supporting people to maintain their health. Relatives who we spoke with praised the care and support from staff in ensuring their family member's health was supported as their needs changed. They provided examples of how staff had responded to changes in their family member's health condition, including medical emergencies, and liaised with other health professionals to maintain their heath and wellbeing. We observed staff supporting the person to reduce the risk of potential pressures areas developing due to their limited mobility. People were supported to access routine and specialist health appointments, such as opticians, GP, dental and mental health services. Where people had declined to attend, this had been recorded in their care plans.

Staff told us they were given training that gave them the knowledge and skills they needed in their role. Staff comments included, "I had a good induction into the service which included four days shadowing (working alongside experienced staff) to get to know people," "We have a lot of training. A trainer comes in and provides training and gives us questions to answer to make sure we have understood the training," and "A lot of training is available which improves your judgement and skills. I have recently completed manual handling, dementia awareness, aspergers and mental capacity."

Staff who were new to the service were supported through induction training prior to supporting people.

This included working towards the Care Certificate; a set of nationally recognised standards which supports staff working in care and support to develop the skills, knowledge and behaviours needed in their roles.

We reviewed the provider's training matrix, a central record of training for all staff, which showed staff were provided with a range of training to meet people's needs. This included specialist training, such as mental health and behaviours that challenge. There were some gaps and anomalies which indicated staff had not always completed the training required of them, including refresher training. The registered manager was in the process of updating the training matrix, had identified staff who required training and made appropriate arrangements for this to be undertaken.

Staff told us they felt supported in their roles. One staff member told us, "There is outstanding support (from managers). They are quick to respond to any issues and have an open ear. I have had supervisions during probation and reviews of my performance. We are constantly being watched through the CCTV to make sure things are right." Another staff member told us, "We can raise concerns anytime with [Name of registered manager] and [Name of deputy manager]. [Name of provider] always tells us if there are any problems we can go to them. I do have supervisions, but not recently. Managers do monitor us to check everything is alright."

People's needs were assessed prior to them moving to the service. This process involved the registered manager meeting with a range of health and social care professionals involved in the person's care to gather the information needed to develop the care plan, identify potential risks and outcomes. The provider was experienced in supporting people with a mental illness and ensured staff adopted a holistic approach to providing care based on best practice. This involved staff supporting people to lead meaningful and stimulating lives and being a part of the local community as much as possible.

We observed staff supported people to eat and drink throughout our inspection. Jugs of juice were available in communal areas and staff regularly provided a choice of hot and cold drinks for people. People shared positive views about the meals. Comments included, "The quality of the food is good. I can choose where I want to have my meal. Sometimes there are two sittings in the dining room," and "I don't make my own drinks or snacks, I know I can but I prefer not to. The meals are good, very appetising. Staff also take me out for meals as I like to try foods from different countries."

We observed the lunchtime meal. We saw people were able to choose where they ate and had been supported to choose from the set menu. Where people required specialist diets, for example pureed or vegetarian, these were provided. Some people required support to eat and drink. Although staff provided this, we saw one staff member standing over a person whilst helping them to eat their meal. This did not promote a positive dining experience or protect the person's dignity. Other staff were sat with people providing supervision where required. People were able to eat at their own pace and their choices were respected. Where one person declined their meal and became anxious at staff encouragement to eat, staff respected this choice and offered the person a large portion of their favourite dessert instead, which they ate. People were enthusiastic about the dessert trolley, which included a choice of five desserts including fresh fruit.

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).

Consent to care was largely sought in line with legislation and guidance. Where possible, people had signed their consent to care and support. This included consent to support to take their medicines. Records did not clearly the process for assessing people's mental capacity and if this was regularly reviewed. Records did not demonstrate the support people needed to make decisions, including complex decisions, and the potential impact of poor mental health on people's ability to make decisions and choices. Where people were subject to DoLS authorisations, for example due to constant supervision, these were in place or had been applied for at the time of our inspection.

Staff demonstrated an understanding of the principles of the MCA. One staff member told us, "I always ask (a person) before I help them and explain what I am going to do. Sometimes they say no and I will try again later, although you have to respect people are able to say no to care." We observed staff seeking consent before providing care and support. One person declined their lunch time meal. We saw staff tried different approaches to encourage the person to eat but the person continued to decline their meal. Staff respected this and offered a lighter alternative in an attempt to encourage the person to eat something, which they accepted.

The premises were adapted to support people to maintain their privacy and dignity in individual apartments. Corridors were individually decorated which supported people to orientate around the premises. We saw people moved freely around the building, including the external grounds. People told us they were able to spend time where they were most comfortable. People were able to personalise their rooms with their own belongings.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff. Comments included, "The staff know me well, they help me. New staff are always introduced to me. Some people get very stressed and the staff are patient and handle it well. There are enough staff here; sometimes they are short but handle it well. Staff are really good with people living with dementia; the way they speak to them and maintain their dignity," and "Staff support me, they don't let me get too low. They take me out and let me do my own thing." A relative told us, "There are a mixed group of people living here. The staff are geared up to integrating everyone. Everyone is treated equally and their particular circumstances recognised and respected. That's why (name of person) fitted in so well. The reason why (name) is still here is because the care is good."

Throughout the inspection, we observed staff interacting with people in a kind, compassionate and friendly manner and being respectful of people's choices and opinions. There was a relaxed atmosphere and staff spoke positively about their roles and the people they supported. One staff member told us, "This is a diverse service, people have very different needs. We treat people as individuals here and support them to be as independent as possible." People were addressed by their preferred names and staff spent time supporting people to communicate and interact.

Staff told us they had enough time to meet people's needs without rushing. We saw staff were attentive and spent time sitting and chatting with people and responded in a timely manner when people required assistance.

People and relatives told us they were involved in their care and made decisions about how their care was provided. A relative told us staff kept them fully involved in their family member's care and listened to them if they wanted to discuss anything or make changes. People's choices and preferences had been taken into consideration. For example, where they preferred to spend their time and how they liked their care and support to be provided.

People were supported to maintain relationships with friends and family who were able to visit when they wished. Relatives told us they were always made to feel welcome by staff when they visited and could visit at any time.

Staff were aware of the need to ensure people's information was kept confidential and not disclosed to anyone without appropriate consent and authorisation. People's personal information was kept securely in designated areas, with access to relevant personnel only.

There was a strong emphasis on staff supporting people to be as independent as possible. People told us they were able to make drinks and snacks if they wished and we saw facilities were available to support this. People were encouraged to be involved in the maintaining their apartments, including domestic work, and supported to do as much as possible for themselves. For example, one person was encouraged to propel themselves in their wheelchair. The person told us this helped them to feel more independent and meant they could choose where they spent their time without having to ask staff for assistance.

People's privacy was respected. We saw staff knock on doors and identify themselves before entering the room. Doors were closed when people were supported with personal care. When people became distressed or anxious, staff intervened in a discreet and timely manner to provide people with the reassurance they needed. These actions helped to uphold people's right to have care provided that maintained their dignity.

People were able to access advocacy services if required. An advocate is an independent person who seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them and defends and safeguards their rights.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan that was personal to them. We found inconsistencies in people's care records and the frequency of care plan reviews. The provider was aware of this and had begun to bring about improvements through reviewing and re-writing care plans into a new format. We viewed care plans that had been transcribed onto the new format and existing care plans. Revised care plans included more person-centred information, such as people's life history, relationships, preferred routines and preferences in the support required. This supported staff to provide personalised care.

Care plans that had yet to be transcribed did not always reflect people's current needs or provide detailed information. For example, one person was described as requiring 'prompting'. Records lacked detail to describe how and when staff should provide prompts. A second person was described as requiring 'discreet supervision'. Again, their care plan lacked details to guide staff on how this should be provided. A third care plan showed the aims and objectives the person had identified from their care. However, records showed these had not been reviewed for three years to ensure they were still relevant. The provider was working towards a target date to complete the updating of all care records.

People and relatives told us they discussed care with staff and were able to make changes if they needed to. One person told us, "I haven't had a review as such, but if I need to make changes, I just tell them [staff] and it's done." A relative described positive communication with staff which enabled them to be aware of changes in their family members care and respond if staff identified the person's needs had changed.

People had access to varied activities. They told us they were able to explore hobbies and interests of their choice and could choose how they spent their time. Comments from people included, "I can do what I like. I prefer to stay in and watch television and the staff respect this," and "I go out with [name of activity co-ordinator]. We go out for meals to different restaurants because I want to try food from different countries. This week I've been bowling and I went to art class yesterday."

The service had an activity co-ordinator and volunteers who supported people to go out into the local community and pursue hobbies and education. These included swimming, cooking, visiting places of interest and in-house activities such as bingo. The activity co-ordinator told us activities were personalised and reflected people's cultural and spiritual needs in addition to specific interests. For example, they had supported one person to go to a local restaurant where staff spoke the person's first language and provided a cuisine from their country of birth. We observed a member of clergy visiting people to support people who were not able to attend their local place of worship. The provider had arranged a day trip to the seaside which was advertised around the service. There was an in-house competition to encourage people to grow the best flower box. We saw people had planted boxes and were encouraged to tend these and support the plants to grow. This range of activities helped to reduce the risk of people feeling socially isolated.

People were supported to communicate and information was provided in their preferred format. The provider was aware of their responsibility to support people to access information in a specific way due to their disability or sensory loss. This was in line with the Accessible Information Standard (AIS). The AIS is a

framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given.

People were supported to share concerns and complaints through the provider's complaints policy. We found the policy required further development to ensure it clearly reflected the external agencies people escalate their complaint to if they were unhappy with the response. There had been no complaints since our last inspection. People and relatives told us they knew how to complain and were confident their concerns would be listened to and acted on. The provider maintained a regular presence in the service and was able to listen to and resolve any minor concerns in a timely manner.

Staff had undertaken training to support people through end of life care. People and their relatives had opportunity to discuss their specific wishes and preferences in how they wanted their care to be provided when they were at end of life. Staff liaised with relevant health professionals to ensure people had access to the healthcare and support they needed.

Requires Improvement

Is the service well-led?

Our findings

Although people and relatives described their experience of using the service as positive and this provided them with the service they wanted, we found there were some parts of the management of the service that required improvement and development. There was a lack of systems in place to identify where improvements were needed and they had not identified the issues we found needing improvement during our visit. These included, ensuring people's medicines were managed and stored safely, maintaining safe practices and procedures to ensure effective infection control, ensuring staff training was completed and kept up to date, maintaining accurate documentation to support effective monitoring of people's health needs and each person having a care plan that accurately described the care and support they needed, including the measures needed to keep people safe.

There was a lack of systems to indicate effective audits and checks of documentation and records. The failure to effectively monitor and assess the quality of the service in order to make necessary improvements is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received positive feedback from people and relatives who described the service has having a positive, open culture. Comments included, "I am happy here. Staff know me well and I have everything I need," "I am happy enough here. I have plenty to do and get on with people," and "We tried many different services for [name of family member] but they were not suitable. [Name] settled here; whatever [name] needs, staff make sure [name] has it. [Name] has been very ill lately and the reason why they are doing so well is because the care is so good." Compliments to the service from relatives and health and social care professionals, praised and recognised the care and support provided.

The service had two registered managers, one of which was the provider, who shared the responsibility of the position. They were supported by a deputy manager and senior care staff. The provider was actively involved in the day to day running of the service and demonstrated that they knew the people using the service and the staff well. This leadership structure supported effective communication and information sharing between management and staff. Staff spoke positively about the registered managers. One staff member told us, "The service is well-managed. They [managers] help us, work with us and are flexible when they need to be." Another staff member said, "[Name of provider] always tells us if there is a problem, come and talk to us (managers). Whatever we need, they make sure we have it. We can raise concerns anytime with them. If there is ever any conflict (between staff), it is discussed, resolved and settled quickly. This helps us to work well as a team."

Staff were supported to share their views through staff meetings. We looked a records relating to staff meetings for May 2018 and saw a range of issues were discussed. These included reviewing incidents to identify learning and improvements. For example, following recent incidents in the service, the provider had met with staff and facilitated discussions about team work, supporting each other and recognising when staff needed 'time out' from intensive situations. The provider also discussed best practice in terms of supporting people living with mental illness.

The provider recognised and supported equality and diversity amongst the staff team. These values were embedded in working relationships between staff. One staff member told us, "Our diversity is recognised, including our cultural needs. For example, managers are aware of key festivals and when we may require time off to celebrate, or if we need shorter more frequent breaks if we are fasting." Another staff member told us, "We work well as a team and our nationality is respected. There is no discrimination."

People and relatives told us they were able to share their views about the service through one-to-one discussions with staff, the registered manager and provider. They told us managers and the provider was always available and approachable and listened to their feedback. This was used to inform how the service developed, for instance the activities provided. The provider had not sent out recent quality assurance surveys but these were planned for the future.

Staff worked in partnership with other agencies, such as health and social care professionals. The service also had links in the local community which supported people to go out independently if they were able to. Commissioners, responsible for funding some of the people using the service, had undertaken a number of quality visits to the service following two incidents of concern. They told us they had found a number of areas of concern which they had raised with the provider. The provider was working to an action plan to bring about improvements.

At the time of our inspection visit the provider had not displayed their ratings on their website. This is a legal requirement. They told us this was due to a technical fault. Following our inspection, this was resolved and the current ratings were displayed on the website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure risk assessments provided the guidance and detail staff needed to keep people safe. Systems did not ensure the proper and safe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not always in place in order to monitor the quality of the service effectively to ensure good governance within the service.