Stonesby House Ltd

Stonesby House LTD

Inspection report

107 Stonesby Avenue
Leicester
Leicestershire
LE2 6TY

Tel: 01162831638

Date of inspection visit:
02 March 2017

Date of publication:
11 May 2017

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 2 March 2017. At our last inspection of the service in November 2015 we found the provider's arrangements for the storage, administration and recording of medicines were not sufficient to ensure people received their medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breach. At this inspection we found that improvement made were sufficient to rectify the breach.

Stonesby House Ltd provides accommodation and personal care for up to 14 adults, many of whom have mental health needs. Accommodation is provided across two buildings, with many bedrooms providing private en-suite facilities. At the time of our visit, there were 13 people living at the service.

There was a registered manager in post. 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.

People felt safe in the service. Staff knew people well and understood their responsibilities to protect people from the risk of harm. There were usually enough staff to provide people's care, but arrangements to cover in the event of unplanned staff absence were not always sufficient to ensure staff provided care in a timely way. Action taken to recruit into vacant care staff posts, plans for a revised management structure and use of agency staff helped to mitigate the risk to people's safety from insufficient staffing arrangements.

People's medicines were managed in a way that kept them safe. People received the medicines they needed when they needed them.

Staff were trained and supported to perform their role and responsibilities. The provider was in the process of supporting all staff to update their skills and knowledge and had developed a revised induction programme to ensure new staff were safely inducted to the service.

The service ensured people's rights and best interests by working within the principles of the Mental Capacity Act 2005 (MCA). Mental capacity assessments required further development to ensure staff were clear in how to support people to make specific decisions about their care and well-being.

People were positive about the food provided; they enjoyed their meals and were supported to eat and drink sufficient amounts. People were supported to maintain and improve their health and well-being. People were supported to access a range of external health professionals when they needed to.

People were appreciative of staff who were caring and helpful. Staff knew people well, treated people with respect and promoted their dignity, privacy and rights when they provided care. Staff ensured people's

independence, known wishes and choices for their care was upheld.

People had their care needs assessed and care plans were put in place to meet their needs. Staff used the information in care plans to tailor their support to individual preferences. This meant that people received personalised care that reflected their wishes and met their needs.

A range of activities were organised for people in the service and within the local community. People spoke positively about being able to choose what they wanted to do when they wanted to do it and were happy with the opportunities provided.

People and relatives were confident they could raise any concerns with the registered manager and felt their complaints would be listened to and acted upon.

People, relatives and most staff had confidence in the management of the service. The registered manager undertook checks and audits to assure themselves that people were receiving good care. However, outcomes of quality assurance were not consistently recorded to demonstrate that effective systems were in place to ensure people received safe and effective care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's safety and welfare had been assessed and managed to reduce the risk of harm to people. Staff we spoke with knew how to keep people safe and demonstrated a good understanding of protecting people from abuse.

There were not always sufficient numbers of staff in the event of unplanned absences to ensure care was provided in a timely manner in order to keep people safe. People were supported to take their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

People received care from staff who were trained to meet their individual needs. Staff sought people's consent before providing care. Additional improvements were needed to ensure mental capacity assessments supported people to make specific decisions about their health and care. People were supported to maintain their health and nutritional needs.

Is the service caring?

Good

The service was caring.

Staff had developed positive, caring relationships with people. People were supported to make decisions about their care and develop their independence. People were treated with dignity and respect and their right to privacy was upheld.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs and preferences. People were supported to pursue their interests and hobbies in the service and in the community. People were confident to raise concerns and complaints and felt these would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People, relatives and staff had confidence in the management of the service. Staff felt supported and enjoyed working at the service.

Outcomes of quality assurance were not consistently recorded to evidence that effective systems were in place to monitor and improve the quality of care.

Stonesby House LTD

Detailed findings

Background to this inspection

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

This inspection took place on 2 March 2017 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service. This included notifications we had been sent and the provider's statement of purpose. Notifications are changes, events or incidents that providers must tell us about. A statement of purpose is a document which includes a standard required set of information about a service. We also spoke with local authority care commissioners responsible for funding some of the people using the service to gain their views about the care people received.

We had not asked the provider to complete a Provider Information Return (PIR) before this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we met with the provider and registered manager during our inspection visit and provided them with the opportunity to share this information with us.

During our inspection we spoke directly with six people using the service and contacted three relatives by telephone for their comments. We also spoke with the provider, the registered manager, four care staff and two visiting health professionals. We observed how staff provided people's care and support in communal areas and we looked at three people's care records. We also looked at four staff recruitment records and other records maintained by the service about staffing, training and monitoring the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service in November 2015 we found the provider's arrangements for ensuring people's medicines were managed, stored and recorded correctly were not sufficient to ensure people received their prescribed medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made to the management of medicines.

Medicines were stored safely. Records showed that staff took daily recordings of the storage areas to ensure the condition of people's medicines was maintained. Medicine Administration Records (MARs) that we looked at had mostly been completed correctly and included a photograph of the person to help staff to identify the correct person to receive the medicines. We saw that staff had changed dates on some MARs records as these had not been printed out correctly to reflect the date in which the new cycle of medicines was to start. We saw errors in terms of staff signing for the wrong date. The registered manager told us they would ensure MARs records were correctly dated by the pharmacist to reduce the risk of errors through staff amendments.

We observed two people being supported to take their medicines. Staff demonstrated that they involved each person as much as possible in the process, offering them drinks with the medicines and supporting them to take their medicines at their own pace. People were offered a choice of where to take their medicines, for example, in the office or in their room. One person was able to tell us medicines they were taking and what they were taking them for.

We saw that each person had a plan explaining how they preferred their medicines to be given to them and the action staff needed to take should a person decline to take their medicines. For example, one person's plan advised staff to remind the person of the benefits of taking the medicines to their well-being in the event they declined their medicines. If this failed, staff were to respect the person's right to decline but notify the GP if the person declined their medicines for more than 24 hours'. Where people were prescribed medicines to be administered as and when required (PRN), these were supported by protocols which provided staff with clear guidance on reasons why the medicines were prescribed and symptoms to observe. This meant people were supported to take their medicines as prescribed.

Staff told us that staff who administered medicines had been trained to do so and that there were regular checks on their competence. Records confirmed this. This meant that there were good systems in place to ensure people received their medicines safely.

People and relatives told us they felt safe in the service. One person told us, "I feel safe because of the staff. The staff talk to me and reassure me. They stop people from taking advantage of me. I like being here, being safe." Another person said, "I feel it's a safe environment. I've had no falls here." Relatives told us they felt their family members were safe in the service. One relative told us, "I feel that [name of family member] is safe. She is much more settled." Another relative said, "I feel that the home is secure, there is always someone around."

Staff had a clear understanding of the provider's safeguarding (protecting people from abuse) and whistleblowing policies and knew what to do if they suspected someone was being abused. Staff told us they would report concerns to the registered manager but felt if these were not responded to appropriately, they would feel confident to take their concerns to the relevant external agencies.

We looked at the ways in which staff minimised the risks to people on a daily basis. There were clear guidelines for staff about the possible risks to each person in a variety of situations. For example, where one person required a hoist to enable them to transfer, their risk assessment included a diagram of the type of hoist and sling they used and what staff needed to be aware of as they supported the person. Another person's risk assessment informed staff that they had a history of making allegations against staff. The risk assessment informed staff they should only provide the person's personal care in pairs and should report all allegations to the registered manager and the person's social worker. Records confirmed that staff had followed these risk assessments. Staff demonstrated that they were aware of the measures to take in relation to specific people in order to keep them as safe as possible. This showed that staff had the information they needed to provide people with safe care.

People had personal fire evacuation plans in place. The dependency assessment of people's needs took account of the support they needed to mobilise in an emergency. This meant staff could support people to evacuate quickly should an emergency arise.

We saw that the provider had systems to provide sufficient numbers of staff to ensure people were safe. The registered manager told us that the staffing numbers were determined by the needs and dependency levels of the people in the home. For example, staffing numbers were increased in the event people required a staff member to support them to attend appointments or activities outside of the service.

People told us they thought there were enough staff on to meet their needs. However, staff and relatives we spoke with told us they had some concerns about staffing levels. One relative told us, "I visit in the week and there are frequently only two staff members on." Another relative told us, "The only problem is the shortage of staff, there are only two staff and a cleaner so they can't do the job as they should. It's always 'wait a minute'." Staff members told us that staffing levels were planned in advance through staff rotas but they struggled to cover shifts at short notice through unplanned staff absence. On the day of our inspection, one staff member had called in absent and staff had to wait until mid-morning for a staff member to arrive to provide the additional support required. Staff told us the impact of this was that they felt they were 'chasing their tail' and trying to catch up for the rest of the day and that sometimes people had to wait for help.

During our inspection we observed staff were busy but had time to spend chatting with people, providing reassurance and support to engage in activities. We observed that when people requested assistance, for example by using the call bells, staff mostly attended to people in a timely manner and people were not kept waiting. However, on one occasion we observed that a person waited 10 minutes before staff arrived in response to the call bell. The person required reassurance and monitoring from staff to support them to manage their health condition. The delay in providing support had the potential to put the person at risk.

The registered manager showed us the staff rota which showed that staffing levels were planned in advance. They told us they were in the process of recruiting to care staff vacancies and in the meantime they were covering vacancies through employing temporary agency staff. They also discussed changes to the management structure which included the appointment of a full-time deputy manager. This would enable the registered manager to provide staff with consistent management support across shifts. The registered manager told us they were working to address staff absence and would ensure there were sufficient numbers of staff to meet people's needs and keep them safe at all times.

All prospective staff had been subject to the provider's full employment checks before working in the service. Checks included evidence of employment history, confirming people's identify and right to work in the UK and making checks through the Disclosure and Barring Service (DBS). The DBS provides information about a prospective staff member's criminal convictions and fitness to work with people using care services. We saw that although staff files included the reference numbers for DBS checks, the date and outcome of the checks were not included. The registered manager told us the information was retained by the provider. They telephoned the provider during our inspection visit and asked for the information to be sent to them to retain on staff files to demonstrate staff were suitable to work in the service.

The provider had processes in place to record and monitor accidents and incidents within the service. Records we saw gave detailed information about each accident and incident. The registered manager told us they reviewed all accident and incident forms to assess what, if any, action was needed to reduce the risk of further occurrences. For example, where an incident had occurred through a person's challenging behaviours, records showed that the registered manager had contacted relevant health professionals and reviewed behaviour management strategies to ensure the person had the support they needed to manage their behaviour. Some accident and incident forms did not include what action had been taken to reduce the risk of harm for the person. The registered manager told us they would ensure they completed all forms fully and signed them to show they had completed their review.

Good

Is the service effective?

Our findings

People told us that they had confidence in the staff. They told us about the support staff provided when they had needed to attend medical appointments and how staff had helped them to follow the advice provided.

Relatives told us they felt staff were effective in meeting people's needs. One relative said their family member's health had "Improved a lot since she's been here."

We talked with staff about how they provided effective care to people with differing needs. They showed that they knew each person's needs and preferences well and had the necessary skills to carry out the required tasks. For example, one staff member was able to describe in detail how they supported a person to manage their behaviours when they became anxious. They were able to describe how they ensured the safety of the person and others and used distraction through talking with the person about their favourite things or moving to a quieter area in the service. This was reflective of the information and guidelines within the person's care plan. This showed that staff were able to provide effective care to meet people's needs.

Staff told us they had completed the training they needed to provide safe and effective care. Where there were gaps in staff training, this had been identified and courses planned and provided through a combination of face-to-face and distance learning training. The registered manager told us they were in the process of updating the training matrix as staff completed their training. Training included essential training, such as manual handling and safeguarding, and specialist training such as challenging behaviours.

New staff working in the service provided us with mixed feedback about their induction. Staff told us they had opportunity to work alongside experienced staff for up to one week before they started to support people. This enabled new staff to be introduced to people and get to know about their needs and preferences. Staff told us they were not always provided with dedicated time to read people's care plans and had done this as and when they could. One staff member told us, "As part of my induction I spent time with the [registered] manager, was shown around the service and worked alongside experienced staff for a few days. I was told to read care plans but I did this as I went along. I had a lot of training in my previous employment so I think I have enough knowledge for this role." Another staff member told us, "I had previous care experience and training so that helped when I started working here. I did undertake a course in managing behaviours that challenge which was really useful as it helped me to understand how to support people." One staff member told us they felt their induction had been rushed and hadn't provided them with time to read people's care plans. They told us they did this during the course of their work.

The registered manager showed us a revised induction programme which was provided over 12-weeks. All new staff were expected to complete the programme which included essential training, workbooks with competency tests, observations, key policies, values of the service and behaviours expected. There was also face-to-face training in areas such as manual handling and managing challenging behaviours. They told us they would ensure that all new staff were provided with opportunities and time to read people's care plans and get to know about people's needs before they started to support them. This would help to ensure that people were supported by competent staff.

Staff told us they felt supported in their roles. One staff member said, "I like working with the staff. We work as a team on the whole. I have had one supervision since I started working here." Another staff member told us, "I can make suggestions to [name of registered manager] and the staff are really good. If I am not sure about anything I can ask managers or staff, there is support there." A staff member explained how the registered manager and provider had supported them personally and professionally and how much they felt valued as a staff member and as a person.

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 decision and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is called Deprivation of Liberty Safeguards (DoLS).

Some people's freedom was being restricted in a way that was necessary to keep them safe. For example, when people were not able to independently choose whether or not to live at the service and people who required 24-hour supervision. We found the provider had followed the legal requirements by submitting applications for best interest assessments and DoLS authorisations. Records showed that the registered manager kept DoLS authorisations under review and had submitted new applications prior to the expiry date of existing authorisations. We looked at two authorisations and saw that the conditions were being met. This meant people were protected from the risk of having their freedom unlawfully restricted.

We saw staff supported people to make choices and asked for their consent before they provided care. For example, we observed staff asked people where they would like to spend their time and if they were happy to take their medicines. People's care plans included their right to decline care and support and provided staff with guidance on the response to ensure the person was safe whilst respecting their decision.

The support people needed to make day-to-day decisions was detailed within their care plans. For example, one person required staff to speak clearly and to repeat information at different times to support the person to understand information to make a decision. Another person was identified as being able to make day-to-day decisions, such as how they spent their time and what they wanted to eat. Staff were directed to refer more complex decisions to the person's relatives who had the legal authority to make decisions in the person's best interests.

Although people's capacity to make decisions in relation to daily living had been assessed, information did not relate to specific decisions to be made. A mental capacity assessment had not been carried out to assess if people were able to make specific decisions, such as moving from the service or decisions about their health and treatment. The provider told us they would develop mental capacity assessments to include the support people needed to make specific decisions. This would help to ensure people's right to make these decisions for themselves was upheld.

People told us they enjoyed the meals at the service. One person told us, "The food is gorgeous, fantastic, amazing." Another person told us the food was "Cooked well." A relative who had sampled the food told us,"The food is not perfect but it is nice." People told us they could eat at different times and had several menu choices. One person told us, "Sometimes I just want marmalade on toast so I have this." We saw staff provided this at the person's request and offered a choice of hot and cold drinks. People were provided with drinks and snacks throughout the day with some people supported to purchase their own from the local shop.

We observed that people who needed assistance from staff to eat their meals received this in a timely way. Some people had adapted cutlery and utensils, such as plate guards on their plates, to support them to eat independently. Where a person was at risk of choking, we saw that staff consulted the person about their meal and asked which foods they would like cut up into bite sized pieces to reduce the risk of choking. One person's care plan included a nutritional risk assessment where staff were to prompt the person to eat as they became distracted during meal-times. During lunch, we saw the person became distracted and left their seat during their meal. Staff were quick to intervene and gently prompted the person to return and finish their meal. This demonstrated that staff understood how to meet people's nutritional needs.

People had their health needs assessed and care plans put in place to meet their needs. For example, where one person required support to monitor their weight, records showed staff provided this by providing information about healthy eating options and monitoring the person's weight on a regular basis. People were supported to access a range of health professionals, including memory clinics, GP and consultants in addition to routine health appointments such as dental and chiropody. People's care plans included a hospital grab sheet which detailed the person's health needs, medical conditions, how they communicated and things that were important to them. This helped to ensure if people were admitted to hospital, staff new to the person had the basic information they needed to meet their needs.

The premises were clean and spacious and provided people with opportunities to spend time as a group or in quieter areas. People's bedrooms were personalised and we observed people were able to move around the service freely. The newest part of the premises provided people with a quiet lounge area and training kitchen and laundry. This supported people to develop the daily living skills they needed in order to move from the premises and become independent. There was a small garden for people to use. We saw that there was some debris including building materials left around the area where people preferred to smoke which could present as potential tripping hazards. We raised this with the provider who told us they would arrange for the debris to be cleared from the site to ensure people could access external areas safely.

Good

Is the service caring?

Our findings

All the people we spoke with told us they felt staff cared for them well and treated them with dignity and respect. Comments included, "I feel I get a good level of care," and "I feel cared for because of the kind way they [staff] look after me," and "Staff are caring because they listen to me when I'm upset and they come straight away when I ring my bell. They [staff] talk nicely to me."

Staff and the registered manager knew people using the service well. They spoke warmly of them and were able to explain their support needs, individual personalities and likes and dislikes. It was evident from the interactions we saw that staff valued people and appreciated their qualities and abilities. One staff member told us, "The people living here are all different. I am constantly learning from them. They are the reason I come into work."

During our inspection we observed some positive interactions between people and staff. For example, one person used a non-verbal method of communication, using signs that were unique to them. Staff told us they had spent time with the person being taught basic signs to enable them to communicate with them. We saw staff regularly approaching the person and using signs to exchange communication and share humour. The person responded positively and showed they enjoyed these interactions. Another person became distressed during our visit. We saw that staff were quick to respond and spent one-to-one time with the person reassuring them and talking about their anxieties and how they could best manage these. These were examples of positive, caring relationships between people and staff.

People were encouraged to express their views and make decisions about all aspects of their lives. Each care plan included a section titled 'This book is about me.' This was a document completed by the person detailing what staff needed to know about them, what was important to them and how they preferred their care to be provided. People's cultural and spiritual preferences was also included. For example, some people were supported attend a place of worship of their choice. Records showed that staff supported people to make decisions about their care. For example, one person attended a staff meeting to inform staff how they wanted their care to be provided and how staff needed to adapt their support to ensure their preferences were met. The registered manager told us this had a significant impact on staff ability to understand and appreciate the importance of consistent support for people. As a result, the person was happy with their care and felt staff had been consistent in their support.

People we spoke with told us staff promoted their independence. One person told us, "They [staff] try to encourage me to do things myself. When I have a shower, I wash the parts of my body that I can. There are two staff supporting me so I feel encouraged and able to cope." Another person told us, "If I can do something for myself, I get encouraged to do that." Care plans focussed on people's abilities and included the support they needed with daily living, such as making drinks and domestic tasks. This meant people were encouraged to maintain and develop their independence.

During our inspection we saw staff were respectful of people's dignity. For example, by ensuring doors were closed when personal care was being provided. Staff provided examples where they protected people's

privacy during personal care by ensuring people were covered. The registered manager told us that where people required two members of staff to support them to transfer, only one staff member supported the person's personal care needs. This was to ensure the person did not feel overwhelmed by the presence of two staff members at times when they felt vulnerable. We observed a person approaching staff to ask for support to read their letters. We saw staff explain the importance of privacy to the person and offer to read the information to them in their room. When the person declined and asked for the information to be read in the communal area, the staff member supported the person to a quiet corner to ensure information was not overheard. This showed staff respected the people they were supporting and the need to protect their confidentiality.

Good

Is the service responsive?

Our findings

People and relatives told us they thought the service provided responsive care. Some relatives described noticeable improvements in their family member's well-being since moving to the service. They told us the home was welcoming, tidy and clean. They said although staff could be busy, they were able to provide the time people needed when they needed it, which meant people's individual needs were met.

People had an assessment of their needs when they moved to the service. People, relatives and health professionals were involved in the assessment which formed the basis of the care plan. Assessments included guidance about people's health conditions, mental health needs and well-being. For example, people's ability to orientate to time and place was assessed in addition to their understanding of their mental health needs. This information was used by staff to ensure the person was supported in line with their assessed needs.

People's care plans were person centred. For example, where people required support with their personal care, guidelines were included in the care plan as to how the person was to be supported and what they liked to have around them, such as favourite flannel or soap. Care plans included a section which profiled the person's life history, likes and dislikes and what the person felt was essential to maintain their health and well-being. For instance, one person had stated that it was important for them to be able to sleep at some stage during the day and not be disturbed by staff. The person told us they were able to retire to their room when they wished and staff respected this choice. This meant that people received care that was personalised and met their needs.

People's care plans were regularly reviewed and referrals made to appropriate health professionals in the event of a change in people's needs. Records showed the date of reviews and comments recorded by staff such as 'no change'. Records did not demonstrate that people were provided with the opportunity to be involved in the review of their care. The registered manager told us they would ensure this would be recorded with future reviews.

People were encouraged to maintain contact and visit their family members, where appropriate. One person told us they went home on a regular basis to stay with their family. Another person told us staff had arranged for them to receive regular telephone calls from their family member to enable them to keep in touch. Staff were in regular contact with relatives to keep them informed about people's care, where appropriate. Relatives and visitors told us they felt they could visit at any time to fit in with people's care and were always made to feel welcome.

People were supported to access education, hobbies and interests that were important to them. One person told us they went to English and computing classes each week to develop their skills. This was confirmed by a visiting support officer who told us, "[Name of person] has learnt daily living skills since moving to the service. Staff take him out, he goes out a lot more now than he did before. He is very happy here." Another person told us how much she enjoyed colouring and word searches. We saw the person was provided with these activities during our visit. A relative told us, "[Name of person is doing so much more since moving to

the service. She can do her hobbies and staff take her out shopping."

There were planned activities displayed on the notice board in communal areas. These included keep fit, arts and crafts, visits to the pub and cake decorating. The registered manager told us, "The planned activities are more of a prompt for staff to make sure there is something for people to do. We discuss with people and ask them individually what they would like to do. We have booked day trips but sometimes people change their mind and don't want to go." We observed people were supported to go out to local shops which were unplanned activities. Staff told us this was in response to people making requests to go out. This showed that staff were responsive to people's individual interests and wishes.

People and relatives we spoke with told us they were confident to raise concerns and felt their concerns would be listened to and acted upon. The provider's complaints procedure supported people to make a complaint and understand how complaints would be responded to. At the time of our inspection, there had been no formal complaints in the last 12 months. The registered manager told us they were open to complaints and took people's concerns seriously to ensure people were satisfied with their care.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that, overall, they had confidence in the management of the service. A visiting professional spoke about staff "Going the extra mile" for people using the service. Staff described an open and honest work culture where they "Supported each other" Most staff had confidence in the registered managers and described as being approachable and felt "She pulls her weight on the floor too."

Local care commissioners, responsible for funding some of the people using the service, told us they were monitoring the service following recent safeguardings (notifications where people may be at risk of harm). Although they had no significant concerns about people's care, they had identified that care records required further development to show that people's care was being provided in line with care plans. The registered manager had made some improvements to care records since our last inspection for this service.

Staff told us they were kept informed about people's care and developments in the service by the registered manager. They told us they had opportunities to share their views and make suggestions, although one staff member felt that registered manager did not always listen to them. One staff member told us, "We have staff meetings where I can voice my opinion or concerns and share ideas for improvements. We are asked our opinion. For example, the [registered] manager asked us to contribute to the review of the evacuation procedure." Another staff member told us, "Staff feed off each other, share ideas. If we have an idea we speak to [name of registered manager] and if she thinks it's good, we can go ahead with discussing it with people and their families."

We looked at the minutes of a staff meeting held in February 2017 and saw staff were provided with information about people's care, new policies and outcomes of DoLS applications. Meeting were also used to support staff to reflect on their roles and responsibilities and best practice. This meant staff had opportunities to share their views and contribute to making improvements within the service.

People and their relatives were supported to share their views informally through day-to-day interactions with staff, through reviews of their care and through satisfaction surveys. The registered manager told us satisfaction surveys had been sent out and completed in 2016 but was unable to locate any surveys to confirm this.

The registered manager carried out audits and checks to ensure people received good care. These included spot checks on staff working practices and the environment and formal audits on care records and medicines. They told us they used audits and checks to improve working practices. For example, they observed staff providing care to ensure this was in line with people's preferences and care plans. The registered manager kept a list of required actions as a result of her spot checks and showed us they forwarded this onto the provider where they were required to take action or provide additional resources. Although there were some records to confirm audits had been undertaken, such as stock checks of medicines and observations of staff working practices, other audits and spot checks had not been recorded. The provider's quality assurance systems were fragmented and did not provide evidence of the frequency and effectiveness of checks and audits and how these were used to drive improvement within the service.

The provider told us they would ensure quality assurance records were in place to ensure people were receiving safe and effective care.

The registered manager understood their legal responsibility. They ensured that the local authority's safeguarding team were notified of incidents that had to be reported and maintained records of key incident. They were aware of their legal responsibility to notify CQC of significant events and incidents within the service. We noted that the provider had clearly displayed their ratings in the service with a copy of the latest inspection report and this was available for people, staff and visitors to read.