Isle of Wight Council

The Adelaide

Inspection report

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Date of inspection visit:
14 May 2019
15 May 2019
20 May 2019

Date of publication:
23 July 2019

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

About the service: The Adelaide is a local authority owned service which provides both a short stay residential respite and re-enablement service, day care service and an outreach community re-enablement service including personal care for people living in their own homes. At the time of the inspection 17 people were receiving a residential based service and 25 were receiving a community-based service.

People's experience of using this service:
People told us they felt safe when they were receiving a residential or community-based service from The Adelaide.
Quality assurance processes had not always been effective. An external consultant had completed a comprehensive audit of the service shortly before this inspection. This had identified significant areas for improvement and the provider had ensured work had been undertaken in respect of the priority areas. Further work to improve the service was ongoing. We identified some areas for improvement and senior managers responded positively acting where needed.
People's needs were met in an individual and personalised way by staff who were kind and caring. Independence was promoted, and the service goals of re-enablement were understood by all staff.
People's rights and freedoms were upheld. People were empowered to make their own choices and decisions. They were involved in the development of their care plans which were designed to promote people's recovery and independence (re-enablement). Staff acted in the best interests of the people they supported.
People felt listened to and knew how to raise concerns. They, and healthcare professionals told us they would recommend the service to others. Staff respected people's privacy and protected their dignity.
There were enough staff who had recently received all necessary training, worked well together and arrangements were now in place to ensure staff received formal and informal supervision from senior staff.
The residential service environment was safe and suitable for people staying there.

The service has been rated Requires Improvement as it met the characteristics for this rating in two of the five key questions. More information is in the full report, which is on the CQC website at: www.cqc.org.uk
Rating at last inspection: The service was rated as Good at the last full comprehensive inspection, the report for which was published in November 2016.

Why we inspected: This was a planned inspection based on the previous inspection rating.

Follow up: We will continue to monitor the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

The Adelaide

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was completed by one inspector and two experts by experience in the care of older people. One expert by experience made telephone calls to people to gain their views about the service and the second spoke with people within the residential part of the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: The Adelaide is a local authority owned service which provides a short stay residential respite and rehabilitation service, a day care service and a community re-enablement service, including personal care for people living in their own homes. People in residential 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. At the time of the inspection 17 people were receiving a residential based service and 25 were receiving a community-based service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of the first day of the inspection. We gave notice of subsequent dates of the inspection to ensure the people we needed to speak with would be available.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports, action plans and notifications. Notifications are information about specific important

events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we gathered information from:
21 people who used the service. Six relatives or friends of people who used the service
Two health care professionals who had regular contact with the service
Ten people's care records
Records of accidents, incidents and complaints
Audits and quality assurance reports
The manager and assistant manager for the outreach community-based service
The interim manager and three assistant managers for the residential based service
Three office-based staff within the community service
Five members of residential care staff and six outreach community care staff
One housekeeper, an administrator and a chef
The provider's nominated individual

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety.
There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:

- Not all risks for people had been assessed and action to mitigate known risks was not always in place.
- Care files contained risk assessments however, these were generic, not person specific and did not cover all risks for each person. Not all individual risks had been assessed and plans put in place to mitigate risks or guide staff as to how risk should be managed.
- Where people were prescribed medicines to 'thin' their blood and were therefore at a higher risk of bleeding should any injury occur, risk assessments and management plans were not in place. This meant we could not be assured that the risks to these people were managed safely. The management team acted promptly following our feedback to undertake risk assessments where these were needed.
- A person with a red area on their sacrum did not have a clear care plan in place to manage this risk and care plans for people living with diabetes lacked individual detail to show how the risks related to this health need should be managed. A person, whose care plan identified that they were at risk of weight loss and malnutrition, had not been weighed. A weight recording chart within the person's care records had not been completed since their admission. A senior staff member confirmed this should have been completed, and that the service did not have suitable weighing scales to enable accurate weights to be made for people with mobility needs. Once we identified these concerns to the management team they initiated actions to ensure people's health related risks would be managed.
- Where there were concerns about the amount people were eating or drinking specific records were kept. However, these were not always fully recorded meaning prompt action may not be taken if people failed to eat or drink adequate amounts.
- Environmental risk assessments had been completed. However, these did not cover all risks posed by the environment. This included the first-floor balcony garden area or the ground floor courtyard garden which included a pond. Once identified to the management team risk assessments for these areas were completed and they undertook to audit environmental risk assessments to ensure all risks were assessed.
- Each person had a personal emergency evacuation plan (PEEP) and staff knew what action to take in the event of a fire. Fire detection systems were checked weekly and other emergency systems such as lights and exits were also monitored regularly.
- Lifting equipment was checked and maintained according to a schedule. In addition, gas and electrical services and appliances were checked and serviced regularly.
- For the outreach community service, individual and home environmental risk assessments had been completed by the community management team to promote the safety of both people and care staff. These considered the immediate living environment of the person, including pets, the condition of their property and safety of care staff.
- Business continuity plans were in place to ensure that people's needs were prioritised in terms of risk

during crisis situations.

Using medicines safely:
● Prescribed topical creams were not managed according to the provider's procedures. In the residential service one person was prescribed topical creams. We found these had not been stored safely and there was no indication of the date these were commenced in use or records to show where and when these should be and had been applied. The failure to record the date containers of prescribed topical creams had been opened meant there was a risk these would be used beyond their 'safe to use' date as per manufactures guidelines. The absence of clear instructions for care staff as to where topical creams should be applied, or how often, meant staff may not apply these correctly. The assistant manager responsible for medicines took prompt action to address this.
● Across both the residential and community service staff who administered medicines had completed medicines training. However, staff had not received formal annual competency assessments as per best practice guidelines.
● Shortly before the inspection the provider had requested a formal comprehensive medicines audit of the residential service to be completed by an external professional. This had identified areas for improvement in the management of medicines. Consequently, the way medicines were managed at the service had been changed. This had included moving the storage of medicines from an office used by assistant managers and care staff to a dedicated medicines room. New systems to record medicines administration were also implemented. Staff administering medicines were positive about the changes that had been introduced and felt the systems were safer.
● The new systems in place ensured medicines were stored, administered and recorded safely. Systems also included a stock count to ensure all medicines had been administered and a record of the time regular medicines were administered. These systems helped ensure people received their medicines safely.
● People told us they received their medicines as prescribed and that they could get ad hoc pain relief such as for a headache if required. We observed residential based staff administering medicines in an appropriate manner. Community based staff described safe systems to manage people's prescribed medicines.

Preventing and controlling infection:
● Not all infection control risks were managed safely.
● A comprehensive infection control audit had not been completed. The provider had identified this and the interim manager for the residential service had been tasked to undertake this.
● When we visited the laundry room we noted that the same containers were used to move clean laundry from washing machines to tumble dryers. Although staff said these were cleaned between use a risk of cross contamination remained. Staff told us the one sink in the laundry room which was used by staff to wash their hands was also used to soak (in a bowl) kitchen cloths prior to washing. This meant that the sink was not available for staff to wash their hands when this was occurring. Action was promptly taken to address these issues.
● The provider's standards of dress and appearance as confirmed by the managers and provider's nominated individual were not always enforced. We identified two care staff with longer and varnished/decorated nails. Best practice guidance states care staff fingernails should be short and free from varnish in order to protect people from the risk of infection and injury. The provider had identified this as an issue and was formally reminding staff of the correct policy for nails which they said would be enforced.
● The local environmental health team had awarded the home five stars (the maximum) for food hygiene meaning safe systems were in place for food storage and meal preparation.
● The residential service was clean and housekeeping staff had completed regular cleaning in accordance with set schedules. All staff, residential and community, had access to personal protective equipment, including disposable gloves and aprons, which we saw they used whenever needed. Secure facilities were

available for the safe storage of waste pending its removal from the service.
● An infection control annual statement had been completed by the residential registered manager. The interim residential manager and outreach community manager were aware of the actions they needed to take should a person have an infectious condition. The actions they described would help reduce the risks to other people, staff and visitors.

Systems and processes to safeguard people from the risk of abuse:
● All staff had received safeguarding training. However, some staff were unsure as to who, outside the provider management team, they should contact if the organisation failed to act if they report a safeguarding concern. Although this information was available on a notice board for staff they were unaware of it. This meant safeguarding concerns may not be reported appropriately and people may not be safe. The interim manager and outreach manager undertook to provide safeguarding referral information directly to all staff.
● The interim manager for the residential service, the outreach community service manager and assistant managers were clear about their safeguarding responsibilities and actions they would take if they had safeguarding concerns.
● People said they felt safe when receiving a residential or community-based service. A visitor said, "We are so glad [person's name] is in such capable hands." Whilst a person said, "I am really well looked after."

Learning lessons when things go wrong:
● There was a system to record accidents and incidents. When these had occurred, appropriate action had been taken where necessary. For example, medical advice was sought and followed when people fell. The provider's policy required all accidents and incidents to be formally recorded and sent to a specific internal department for review.

Staffing and recruitment:
● There were enough care and ancillary staff available to keep people safe.
● People receiving a community-based service said staff came on time and stayed for the correct amount of time. People receiving a residential based service also felt staff had the time to meet their needs and did not feel rushed. One person said "You never have to wait long for help. There's always someone there straight away!"
● The manager for the outreach community-based service, was clear they would only accept new referrals for people if they had enough staff to meet their needs. Within the residential based service, the interim manager and assistant managers told us how they would decline referrals if they were unable to meet the person's needs. For example, the weekend during the inspection they had declined a referral of a person who would require two staff for all care. The service was already providing a high level of care for other people and senior staff felt they would be unable to meet further needs for this level of support.
● All care staff told us two staff were always available when specific equipment or two staff were required to assist people to move safely. This meant equipment could be used safely and people would be supported in a safe manner. Care staff said they felt they had time to meet people's needs and did not feel rushed. They felt they had time to support people to undertake tasks themselves even though this may take longer.
● Recruitment procedures were robust to help ensure only suitable staff were employed. A recent audit had been completed of staff recruitment files and action was being taken to obtain any missing information such as gaps in employment records. A record was in place of any staff health needs which may impact on their ability to perform their roles meaning reasonable adjustments, if required, could be made.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience:
- Staff had completed a range of training to give them the skills necessary to meet people's needs.
- People told us staff knew how to care for them. One person said "They [staff] seem to know what they are doing." A relative said, "I can't speak highly enough of the carers."
- New staff received an induction which ensured they received any necessary training and time spent 'shadowing' experienced staff until they felt confident to work unsupervised. Staff without a care qualification undertook the care certificate, which is a competency-based training programme to give social care staff the skills they need, as part of their induction. Care staff were supported to obtain recognised care qualifications. Ancillary staff such as chefs and housekeepers also confirmed they received a range of relevant training.
- The provider's policy for supervision stated all staff should receive formal supervision every six weeks. Records viewed for residential staff showed that this had not been occurring and some staff had received one supervision in the year prior to the inspection. The lack of supervision for residential based staff had been identified during an audit by an external consultant and new systems were being introduced to ensure staff received more regular supervision.
- Outreach community staff were receiving regular supervision including unannounced monitoring of their practice (spot checks).

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
- Prior to admission to the residential or outreach community service, an assessment of people's individual needs was completed. This was completed by staff specifically employed for this role and based at the local hospital, or by senior staff based at the service. Information from these assessments was then forwarded to the assistant managers of each part of the service for consideration. The assistant managers told us they reviewed the assessments and could clarify information if required. They were then able to decide if the service could meet the person's needs. Assistant managers told us they would only agree to commence a service when they could meet the person's needs. A copy of hospital discharge documents was kept within care files. The pre-service arrangements would help ensure all needs were known and therefore could be met following commencement of a service.
- The assessment included people's physical, social and cultural needs. People and relatives if appropriate, were involved in the assessment process.
- The focus of the service was to promote people's independence and to provide a re-enablement service. Staff were clear that they would work to achieve these goals with the person and records viewed confirmed this. Care plans identified people's needs and the choices they had made about the care and support they received.
- Outreach community-based care staff told us that when they identified a change in people's needs, they

would contact the office for a reassessment and review of the person's care plan. They also said that if they felt more time was needed to complete a care visit the management team took prompt action to address this.
● People were happy with the care they received. One person receiving a residential service said they received, "Really attentive care. Such a relief." Whilst a person receiving an outreach community service said, "The carers give me the support I need."

Supporting people to eat and drink enough to maintain a balanced diet:
● People were all positive about the meals they received and confirmed they were offered a choice. Meal times were sociable occasions and people were not rushed. Choices were offered at the time of meal service.
● People receiving a residential service were offered a choice of food and drink, including regular snacks. They told us meals were of high quality, the menu was varied, the portion sizes were good with second helpings always available. People also told us meals were always served hot. One person said, "very nice, always is" when asked if they were enjoying their meal. ● People receiving an outreach community-based service, confirmed care staff would ask them what they wanted before making any meals for them. People receiving an outreach community-based service also said care staff remembered to leave drinks and snacks, where required.
● Catering staff were aware of people who required a particular diet to meet medical needs and told us this information was always provided for them.
● We saw, where needed, people received appropriate support to eat and were encouraged to drink often. Where there were concerns about the amount people were eating or drinking specific records were kept, although as previously described these were not always fully completed. During the inspection the interim manager acted to improve the recording of food and drinks people had received by keeping these records closer to where people spent time during the day.

Staff working with other agencies to provide consistent, effective, timely care:
● The service was closely linked with local NHS hospital and community services with a view to preventing unnecessary hospital admissions and ensuring people could be discharged from hospital in a prompt manner. Some staff responsible for assessing people's needs prior to receiving a service, were based at the local hospital.
● Should a person need to be admitted to hospital, staff provided written information about the person to the medical team, to help ensure the person's needs were known and understood.
● Community outreach staff worked with social services staff to ensure appropriate information was available if the person required ongoing community support, which would be provided by another domiciliary care service.
● A community health professional told us they were contacted appropriately by the service should people have a medical need whilst in the residential service.

Adapting service, design, decoration to meet people's needs
● The residential service was suitable to meet the needs of older people with reduced mobility. Most bedrooms were located on the ground floor and all were situated near bathroom and toilet facilities. Some bedrooms had ensuite facilities and all were suitably equipped to meet the needs of their occupant. Six bedrooms were located on the first floor. Staff told us careful consideration was given to people accommodated in these rooms to ensure they were more independent and the rooms were suitable for them. A passenger lift was provided to enable people to access the first floor of the home.
● There was access to level outside places and within the home there were a range of communal areas suitable for the number and needs of people who accessed the service. Signs were in place to help people

move around the home and find facilities such as toilets near to the communal areas.

Supporting people to live healthier lives, access healthcare services and support:
● People were happy with care staff who they told us they supported them to access healthcare services. One person told us, "I am really well looked after."
● Care plans included information about people's general health, current concerns, social information, abilities and level of assistance required. This allowed person centred care to be provided.
● Staff were able to tell us about individual people and the care, including health needs, they required.
● Staff worked well with external professionals to ensure people were supported to access health and social care services when required. A visiting health professional told us, "No worries here, the staff know when to contact us and do so appropriately." They provided examples of when staff had requested advice and confirmed staff followed their recommendations.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act (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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA and found that they were.
● At the time of the inspection we were informed that everyone using the service had the ability to consent to the care that was provided for them. Staff were able to describe how they would support some people to make choices, such as showing them options and were clear that people had the right to refuse planned care at any time. Staff also understood the actions they should take should a person be unable to give informed consent.
● Residential service care files contained a consent form. Apart from one person, people had signed their own consent forms. One form had been signed by a close relative of the person. We were unable to establish why the person had not signed their own form and other information in their care file indicated that they were able to make decisions. Community care files had been signed by the person to show they had been involved in discussions as to how their care and re-enablement needs would be met.
● People and relatives told us they were always asked before care was provided. For example, one person said, "The carer always asks if I want the care." Another person said "They [care staff] help me with the shower when I ask."
● Senior staff understood when DoLS were needed. They identified that the service was unsuitable for people where restrictions they were unable to agree to would be in place and that this was considered during the pre-service assessment process.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
- People were unanimous when asked if the carers were caring. They all told us they were treated with kindness and consideration. One person said, "The staff are so friendly." Another person said, "You can't fault the staff." Whilst a third said "The carers are lovely, I'm looked after very well, and the carers understand my needs."
- Within the residential based service, we observed people were treated with kindness and compassion by staff. Staff spoke respectfully to people and supported them in a patient, good-humoured way. One person told us "They [care staff] are very patient."
- People's protected characteristics under the Equalities Act 2010 were explored as part of their needs assessments before they began using either a residential or community-based service. Staff explained how they met people's individual needs.
- People's diverse needs were detailed in their care plans and people confirmed they were met in practice. This included people's needs in relation to their culture, religion, diet and gender preferences for staff support. Some staff had received equality and diversity training.
- Staff spoke fondly about the people they supported. All staff said they especially enjoyed seeing people gain independence and do things they previously had not been able to complete on their own. For example, one staff member said, "What I really like is when people realise they don't need help with something, that's so positive for them but also for me as I know I have contributed to their recovery."

Supporting people to express their views and be involved in making decisions about their care:
- Most people were aware of their care plans and confirmed they had been involved in discussions about their care and how this would be provided. On a day to day basis people were also included in decisions about their care. One person said, "Ask and it's done." People receiving a community-based service confirmed they were regularly contacted by senior staff and reviews of their care were undertaken. One relative told us, "The package of care is under review at the moment, and a change is pending."
- People receiving a residential based service also confirmed discussions about their care on an ongoing basis. One person said, "I know what the plan is and how I will be helped to get home."
- People were given a choice of male or female care staff. This information was included within care records viewed and was part of the pre-service assessment process.
- Staff showed a good awareness of people's individual needs, preferences and interests. Care files included some information about people's life histories and their preferences. This meant staff could use this information when talking with people.

Respecting and promoting people's privacy, dignity and independence:

● People confirmed they were encouraged to be as independent as possible. One person told us, "I like to be independent, but I know they keep an eye on me." A relative told us, "The carers from re-ablement are fantastic. They have helped my father to keep his dignity after being released from hospital. He is now getting to the bathroom with their assistance and managing to [maintain his own personal hygiene]." People also told us they were treated with dignity and respect.

● The service's primary aim was to re-enable people to become more independent. Staff were clear that this was their role when providing care. Outreach community-based staff told us they could request additional time for home visits if this was required to enable people to undertake more tasks themselves. Residential based staff told us they had enough time to enable people to be as independent as possible.

● Care staff knew the level of support each person needed and what aspects of their care they could do themselves. They were aware that people's independence was paramount and described how they assisted people to maintain this whilst also providing care safely.

● We saw staff encouraging people to walk within the residential part of the service. Staff did not rush people and ensured they felt safe and confident. For example, a second staff member was seen following a person with a wheelchair should the person feel the need to rest whilst walking.

● Staff explained how they respected people's privacy and dignity, particularly when supporting them with personal care by, for example, ensuring doors were closed and people were covered up.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People received individualised care which met their needs.
● People confirmed that care staff would do what was required and asked of them. A person receiving an outreach community service said, "The carers give me the support I need, they quickly respond when I ask for anything." People receiving a residential based service told us staff responded promptly when call bells were used and consistently and promptly met their needs.
● We saw staff responded promptly to people's requests for support and identified when people's needs changed. For example, we saw a person become unwell during the inspection requiring prompt medical support. The staff member with the person noted the problem and was immediately assisted by senior staff who provided appropriate first response care. Paramedics arrived quickly and efficiently took over. At no time was the person's dignity compromised and other people continued to receive the support they required unaware of the urgency of the situation.
● The care planning process for the residential service had been reviewed shortly before this inspection. New systems had been introduced and staff were still getting used to these. We saw an audit of the care files had been completed identifying where additional information and improvements could be made. Once fully embedded into practice the new system would ensure that all needs including, health, personal, social and diversity would be identified and information available as to how these needs would be met by staff.
● Within the outreach community service, the care planning system was established and provided comprehensive information as to how needs should be met. Care plans were reviewed on a regular basis reflecting people's changing needs.
● Within the residential service people were provided with opportunities to participate in a range of activities. These were organised by care staff each afternoon. Care staff said that should people not wish to undertake a planned activity they would offer alternatives.
● The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw at lunch time one person was shown plates of both lunch time main meal options to facilitate a choice. Signs were available around the residential service to help people navigate their way around the environment.

Improving care quality in response to complaints or concerns:
● People told us they would speak to a member of staff or a manager if they had a concern or complaint. One person told us, "I have no complaints what so ever but if I did I'd talk to the manager."
● The provider had a complaints policy. Information about how to complain was available for people.
● No formal complaints had been received in the year preceding the inspection. The management team were aware of how complaints should be recorded and responded to in line with the provider's procedures. This would ensure people received a written response and provided information as to their options should

they not be happy with the outcome of the complaint.

● When people ceased receiving a service, they were given with a survey form requesting information about their views of the care they had received. This provided an opportunity for people to make any concerns or complaints known to the service.

End of life care and support:

● No one was receiving end of life care at the time of the inspection. The management team were clear that the service would not accept people specifically for end of life care as this was not the focus of the re-ablement service. However, both the residential interim manager and outreach community service manager stated that, should a person receiving a service require end of life care, they would seek relevant professionals to support and guide care staff.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility: Continuous learning and improving care:

- We were told that following a CQC inspection of a similar service owned by the provider where concerns were identified, an audit of the service by an external consultant was commissioned. We were provided with the subsequent comprehensive action plan which covered many aspects of the service. The action plan showed that, whilst some actions had been completed, others remained as requiring action and there was a need for the improvements to be further refined and embedded into practice. Prior to this the provider's quality assurance systems had been ineffective and placed people at risk of not receiving a safe effective service.
- Following the external audit of the service the management team took decisive action to address the key areas identified. For example, in April and early May 2019 the service was closed to new admissions whilst staff completed outstanding training. New arrangements for the safe management of medicines were introduced and staff had received updated medicines training. Care plans and records had been redesigned within the residential service and we saw these were being closely monitored with areas for improvement within each file identified. Staff files had also been reviewed and missing information where identified was being obtained. The training matrix showed that most training had been completed in April and May 2019 following the comprehensive review of the service. Staff told us that until this time training had been harder to access but now they were "all up to date."
- During the inspection we identified areas which required improvement which are detailed in previous sections of this report. Where we identified improvements, such as the need for suitable scales to enable people at risk of weight loss and who were unable to stand without support, prompt action was taken.
- There remained some areas that required formal audits such as infection control and the community-based services medicines management. There were plans in place for this to be undertaken and where we found areas for improvement in respect of infection control immediate action was taken.
- Senior staff for the provider organisation were clear that all necessary action would be taken to ensure all areas identified in the improvement plan were completed. There was evidence that where areas for improvement were identified in other services owned by the provider this was implemented across all the providers services.
- There was a management structure in place, consisting of the registered manager, manager for the outreach community service and senior staff responsible for the day to day management of the service. Each had clear roles and responsibilities which they understood and had the necessary skills to undertake.
- Staff were organised and carried out their duties in a calm, professional manner. They communicated well

between themselves to help ensure people's needs were met, including during handover meetings at the start of each shift.
● Comments from residential and community-based staff included: "I really enjoy my job. I get lots of support from the managers and also from everyone I work with", "I can always get support or help if I need it" and "although I'm new I already feel part of the team".

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

● People told us the service was run well and said they would recommend it to others. One person said, "I'd willingly recommend this place." Another person said, "I am really well looked after."
● Senior staff had a clear vision that the service was an integral part of the local health and social care strategy to enable people to receive the best possible care close to home, prevent unnecessary hospital admissions and promote independence. From our observations and discussions with staff it was clear that staff understood and shared this vision.
● Senior staff demonstrated an open and transparent approach to their roles and acted promptly to all feedback provided during this inspection. Where we identified areas for improvement on the first day of the inspection, immediate plans were put into place to address these areas. For example, on the third day of the inspection areas identified on the first and second days such as missing environment risk assessments had been addressed. Senior staff were able to make decisions autonomously. For example, when we identified a need to have suitable weighing scales or additional laundry baskets these were promptly purchased without the need for the provider to agree funds.
● The provider understood the requirements of their registration. They had notified CQC of all significant events and had displayed the previous CQC rating prominently in the entrance hall of the residential service. There was a duty of candour policy in place to help ensure staff acted in an open way if people came to harm. Senior staff were clear as to when and how this should be used.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● The service consulted people in a range of ways. For many people the service provided was for short term, time limited re-enablement. When this was completed all people were offered the opportunity to complete a questionnaire survey about the care they had received. The provider's process was for these to be collated annually. The results for the community-based service had been collated and we were provided with the report for 2018. This showed people were positive about the service they had received. Surveys for the residential based service for 2018 had not been collated into a report however, completed surveys viewed were positive about the service people had received.
● Care records showed that there was regular and frequent contact between the community service senior staff and people. This included both telephone contact and face to face reviews. This enabled people to be involved in decisions about their care and also to ensure the service provided was meeting their needs. Most people in the residential based service had only been receiving a service for a short period of time. Two people had been receiving a service for a longer time and there was a need to formally review their care and determine future care options. Senior staff undertook to complete these reviews and forward planning for the person.
● Staff told us they felt engaged in the way the service was run and enjoyed high levels of morale. They gave examples of where they had made suggestions for improvement, which had been adopted.
● The service experienced low levels of staff turnover. Staff said they were happy working for the provider and felt able to raise issues or concerns with the management team.

Working in partnership with others:

● Both the residential and community-based service had very close links with local health and social care services and worked in collaboration with all relevant agencies, including health and social care professionals.

● Some staff were based within the local hospital to ensure prompt pre-service assessments were completed. This facilitated smooth, effective hospital discharges and also involved community professionals to prevent hospital admissions, wherever possible.

● Should people need to move to a longer term residential or community-based service senior staff were clear about the need to share information to ensure a smooth transfer of care to new providers. This all helped ensure people received the right care and support when they needed it.