# Counticare Limited

# Grosvenor Court

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

## Overall summary

The inspection visit was unannounced on 15 October 2014. The previous inspection was carried out in December 2013, and there were no concerns noted.

Grosvenor Court is registered to provide accommodation and personal care for up to 17 people who have a moderate to severe learning disability or have autism. The service was only providing accommodation for up to 13 people, as the double rooms had been reduced to single occupancy. At the time of the inspection there were 11 people living in the service.

The service is run by a registered manager, who was present on the day of the inspection visit. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

Staffing levels were assessed according to the dependency of the people's needs. The current levels were not always sufficient to make sure people received

# Summary of findings

their additional one to one support in a timely way, which also had an impact on people, not being able to access the local community as part of their planned activities. There was no domestic staff employed at the service, therefore the care staff had additional duties to carry out during their planned shifts. Therefore, we could not be sure that there were sufficient numbers of staff on duty to make sure people's health and welfare needs were fully met.

There were effective systems in place for ongoing staff training, including individual staff meetings, support and appraisals.

Staff files contained the required information, to show people were protected by robust recruitment procedures. New staff were taken through an induction programme, which included basic training subjects. They also worked alongside established staff, until they had been assessed as being competent to work on their own.

People were protected from the risk of harm, as staff had received appropriate safeguarding training and were aware of how to recognise and process safeguarding concerns. Staff knew about the whistle blowing policy, and were confident they could raise any concerns with the registered manager or outside agencies if needed.

The home had risk assessments in place for the environment, and for each individual person who received care. Assessments identified people's specific needs, but did not always show how risks could be minimised. There were systems in place to review accidents and incidents and make any relevant improvements, to help reduce the risk of further occurrence.

Medicines were managed and administered appropriately. People received their medicines on time.

People were observed enjoying their lunch and had a choice about what and where to eat. They were supported to eat or drink to help ensure they received adequate food and drink.

Relatives told us that they were involved in their care planning, and that staff supported their family member in making arrangements to meet their health needs. Care plans had not always been reviewed and amended to show any changes in people's individual care. The registered manager had an action plan in place to address this shortfall.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and related assessments and decisions had been properly taken.

Staff were familiar with people's likes and dislikes, such as if they liked to be in company or on their own, and if they liked to take part in group activities.

The organisation had systems in place to obtain people's views. These included formal and informal meetings, quality assurance surveys and daily contact with the registered manager.

Systems were in place for monitoring and auditing the quality of the service. The organisation's quality team carried out regular visits to the home. The team completed audits of the systems and practice to assess the quality of the service, and findings were then used to make improvements.

Staff were fully aware of the ethos of the home, in that they were there to work together to provide people with personalised care and be part of the continuous improvement of the service.

The registered manager investigated and responded to people's complaints, according to the provider's complaints procedure.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Requires Improvement**

The service was not always safe. Staffing levels were not always sufficient to make sure people's needs were fully met.

Relatives told us that they felt their family member was safe living in the home, and that staff cared for them well.

Staff had received training in identifying and reporting abuse and knew their responsibility in keeping people safe. Any concerns were taken seriously and were appropriately investigated and addressed.

There was a maintenance programme in place and equipment was checked and serviced regularly to help ensure it was safe to use.

**Is the service effective?**

**Good**

The service was effective. Relatives told us that the staff knew their family member's individual needs and promoted their independence.

Staff were suitably trained and supported to provide effective care. They were familiar with people's individual care plans and knowledgeable about their care needs. There were systems in place to support people to be make decisions about their care and meetings had been held with professionals to ensure that decisions were made in people's best interests.

People's health needs were met; and referrals were made to health professionals when needed.

**Is the service caring?**

**Good**

The service was caring.

Relatives said the people living in the home were treated with respect and dignity, and that staff were helpful and caring. However not all records showed that information was being recorded in an appropriate manner.

Staff ensured that people's privacy and dignity were respected. They treated people with kindness and affection, and responded quickly to their requests for help.

People with complex needs were being supported by advocates and family to ensure that their individual needs and wishes were taken into account by people that knew them well..

**Is the service responsive?**

**Requires Improvement**

The service was not always responsive to people's individual needs, as some care plans required updating.

# Summary of findings

People were being supported with their chosen activities, however, on occasions, due to the lack of one to one staff support these were being restricted such as accessing the community on a more regular basis.

People and their relatives were involved in the planning and reviewing of care needs. The service used a personalised care planning approach and people and their relatives or representatives were involved in assessing and identifying individual needs.

Relatives told us that they knew how to raise concerns and records showed that complaints were dealt with appropriately.

**Is the service well-led?**

**Requires Improvement**

The service was not always well-led.

Records were not always accurate and some lacked detail to reflect the care people were receiving.

The staff were aware of the home's ethos for caring for people as individuals, and the vision for on-going improvements. Staff said the registered manager was supportive and always available.

The company had auditing systems in place to identify any shortfalls or areas of weakness, and action was taken to deal with these. There were systems in place to monitor the continuous improvement of the service.

# Grosvenor Court

**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, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 October 2014 and was unannounced. The inspection was carried out by two adult social care inspectors. Before the inspection, the provider completed a Provider Information Return (PIR). This 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. Prior to the inspection we reviewed this information, and we looked at previous inspection reports and notifications received by the Care Quality Commission.

We contacted eight health and social care professionals and received feedback from two professionals via email from the local social services and community learning disability team.

Most of the people who used the service were not able to communicate with us to express their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with one person using the service, two relatives, the registered manager and four members of staff.

We observed staff carrying out their duties, such as assisting people to move from wheelchairs into armchairs; and helping people with food and drink. We reviewed people's records and a variety of documents. These included three people's care plans; four staff recruitment files; the staff induction and training programmes; medicine records, risk assessments and quality assurance surveys.

Requires Improvement

# Is the service safe?

## Our findings

People who lived in the home were not always safe because at times there was not enough staff to provide the support people needed. Relatives also said that they could do with more staff on duty. They said: "Staff sometimes seem very pushed and rushed off their feet, but overall there is enough".

Staffing levels had been assessed to the needs of the people using the service however this was not being achieved as it was clear from the staff rota's that on occasions people were not receiving their one to one allocated hours as there was not enough staff on duty. On the day of the inspection a staff member had reported sick and had not been replaced. Care staff were also required to undertake the laundry and cleaning responsibilities within the service. The cook's position was currently vacant and this was also being filled day to day by the care staff team.

Three people required two care workers to carry out their personal care, and four other people had additional one to one hours funded by their local authority. Records showed that recently these had not always been delivered. For example, one daily report stated "(person) chose activities as there is no staff for one to one support". According to records on four days during October the one to one support had not taken place. The registered manager told us if the support did not happen one week it was made up by increasing the hours another week, although we did not see evidence of this.

Staff told us that they did not feel there was sufficient staff and that at times, after the one to one support had been allocated, this only left two or three staff on duty. Staff said, there had also been occasions where they had been short staffed. For example, sometimes there had been only three staff on duty instead of four, and other times when there had been no one available for mid shifts (a mid-shift was a shift that overlapped the morning and afternoon shift). People using the service therefore did not always have their full needs met, including choice of activities, due to the lack of staffing levels.

Staff said that sometimes the cleaning "goes amiss" as they were too busy meeting people's needs. Some areas of the premises, such as skirting boards and door frames were not clean, and carpets were in need of hovering as staff had not had time to do this to ensure that people were living in a pleasant and clean environment.

The registered manager told us that when there were gaps in the rota these were filled by existing staff and agency staff were not used due to people's complex needs. The manager felt, at the time of the inspection, there were not sufficient staff to call on in order to fill the rota and the one to one support, given the vacancies and leave commitments, although they were recruiting staff.

Due to staffing issues there was not always sufficient staff on duty to meet people's needs.

This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that all the checks and information required by law had been obtained before new staff were offered employment in the home. Three staff files showed that recruitment procedures included proof of the applicants' identity, including a recent photograph; satisfactory evidence of conduct in previous employment; a full employment history with any gaps in employment discussed; and Disclosure and Barring System (DBS) checks. Successful applicants were required to complete an induction programme; and were on probation for the first three months.

Relatives told us that they were confident their family member was looked after safely. Relatives we spoke with were clear about how to report any concerns and would not hesitate to discuss any issues with the manager. During the inspection interactions between people and staff were good. Staff were patient and caring in their approach and people were able to make their needs known, sometimes using non-verbal body language and hand signs. Staff had received training in how to protect people from abuse and were clear about the internal reporting procedures for any suspicions of abuse or neglect. They were not all so clear about the correct procedure for reporting abuse outside of the service, or how to access the safeguarding policy. The registered manager was familiar with the process to follow if any abuse was suspected in the service; and knew the local Kent and Medway safeguarding protocols, and how to contact the Kent County Council's safeguarding team.

Requires Improvement

# Is the service safe?

Risks associated with people's health and welfare had been assessed. For each risk assessed there was guidance in place about how to keep people safe. For example, risk associated with bathing a person. The risk assessments to move people safely had details of what equipment was needed and where to position this, but they did not always have detailed guidance of how to do this safely. For example, one assessment noted "ensure this person is in the correct position in the wheelchair", but it did not give guidance of what the 'correct position' was so that staff could be confident that the person was being moved consistently and safely.

Where people displayed behaviours that may challenge, such as physical or verbal aggression, the registered manager had involved health care professionals in developing the guidelines that would keep staff and people safe in the least restrictive way.

Accidents and incidents were reported and clearly recorded. The registered manager then reviewed these, to help ensure appropriate action was taken to reduce the risk of further similar occurrences. The registered manager told us that any accidents and incidents were also recorded on a computer system and forwarded to senior managers within the organisation for further action if required, and periodically an overall analysis was undertaken by a health and safety consultant, who monitored events for trends and on-going learning.

The premises had recently undergone some redecoration and refurbishment work. Corridors had been redecorated, new flooring provided and there were new dining room chairs. However there were still areas of the service which needed attention, such as new flooring and redecoration of some people's bedrooms. There were a lack of radiator covers to reduce the risk of people burning themselves, the window in the small dining room had a sharp broken handle and the window opposite had broken seals. After the inspection the registered manager told us that the broken window handle and seals had been repaired. They also sent us a copy of the new maintenance plan, which included all areas of the premises that required attention and confirmed that the plan had been submitted to their head office.

People had the equipment they needed to meet their needs. This included a specialist bath, overhead tracking hoists, mobile hoists and grab rails to support people with their personal care. Records confirmed that equipment checks and servicing were routinely carried out to ensure the safe use of equipment.

After the inspection we asked the provider to send us their improvement plan, together with their plan of maintenance and confirmation of their electrical safety inspection certificate. We asked for this information to confirm on-going maintenance and improvement to the premises. The electrical testing certificate was requested to confirm when the next electrical installation inspection should take place. This information was satisfactory and provided by the service in a timely manner.

Medication records showed that medicines were prescribed for people and given to them safely. Regular medication reviews ensured that people continued to have the medicine they needed. There was detailed guidance if people needed to receive their medicines with their food.

Medicines were stored safely and records were kept for medicines received, administered and disposed of. There were systems in place to make sure people received pain relief medicine when they needed it. For those people who lacked communication there were guidelines in their care plans as to how they may exhibit pain.

Staff training, regular supervision and observations of administration helped ensure staff remained competent in medicine administration.

There was a business continuity plan in place for foreseeable emergencies, such as fire, so that staff knew what action to take to protect people in these circumstances. There was also on-call management arrangements in place to provide additional support if required.

Good

# Is the service effective?

## Our findings

A relative told us that their family member liked their own company and had their own routine, which was known by staff and respected. They said their family member was unable to communicate verbally, but staff were excellent at knowing when something was wrong. They said staff were "well trained and know what they are doing".

People smiled and reacted to staff positively when they were helping them with their daily routines. Care plans contained clear information about how a person communicated and how they expressed things, such as pain or wanting a drink. Staff were patient and not only acted on people's verbal communications, but people's expressions and behaviours.

Staff had undertaken training, which reflected their job role. New staff received a period of induction, which included in-house training, the organisation's induction programme and

shadowing experienced staff. Records and discussions with staff confirmed they had

received appropriate training. For example, fire safety at work, first aid and safeguarding

adults. There was a training plan in place and staff told us they received refresher training. Specialist training was also provided, such as epilepsy, pain awareness and percutaneous endoscopic gastrostomy (PEG) feeding (a PEG feeding tube is a tube which goes directly into the stomach).

In addition, all of the staff had received specialist training in Autism. This included SPELL training (a framework to understanding how to communicate with people living with autism), and Alternative and Augmentative Communication, (systems that aid communication for people who cannot use their voice). Further training from the local Speech and Language Therapy team was also arranged to aid staff interaction with the people.

Staff told us they attended appraisals and one to one meetings where their learning and development was discussed and they also had their practice observed. Staff said they felt well supported. The staff commenced training during their induction, and had a three month probationary period to assess their overall skills and performance. The registered manager told us that she was in the process of re-structuring the induction programme, to make it even more effective in equipping staff with the right knowledge and skills to help enable them to carry out their roles and responsibilities.

The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (DoLs) provides a process by which a person can be deprived of their liberty, in a care home or hospital, when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager told us that five people had an Authorised Deprivation of Liberty Safeguarding in place and another four applications were in the process of being submitted or processed. The service was complying with the conditions applied to the authorisation. Staff understood the importance of people being able to express their day to day choices and encouraged people to do so. Procedures were in place and had been followed when arranging a "best interest" meeting for more complex decision making, such as sedation for dental treatment. People's relatives and health and social care professionals, such as case managers, had been involved in the meetings. The local community learning disability team told us that the service had made appropriate referrals when required.

Relatives told us that the food was "very good here". People had adequate food and drink. Staff told us that some people were involved in the menu planning and that pictures and recipes books were used to help people make choices. However the pictures of the food on the notice board in the dining room had not been updated to reflect what was for lunch that day. The board showed pictures of fish and chips and shepherd's pie, but beef stew was on the lunch menu for that day. We observed that people choose what they wanted to eat and saw that some people required special diets or their food to be liquidised and this was catered for. Staff were sensitive when assisting people to eat and drink, and did not rush them. One person's meal was left on the table for some time whilst they went off to the toilet. Staff noted this and reheated the meal when the person returned. The person then indicated that they did not want the meal and they were offered an alternative of sandwiches and a choice of crisps, which they ate.

Records showed that where appropriate, staff involved health professionals, such as dieticians to undertake assessments of people's eating and drinking needs and

Good

# Is the service effective?

their guidance was incorporated into the care plan. People's weight was monitored regularly to help ensure it remained stable. Staff told us that action would be taken if there was a significant change.

People were supported to maintain good health. The staff had regular contact with visiting health professionals to ensure people were able to access specialist advice and treatment when required. Relatives told us that staff "spot things quickly and call a doctor" if their family member was ever unwell. People had access to a variety of health professionals, such as speech and language therapists, dentists, community learning disability team, psychiatrist, doctors and community nurse.

Good

# Is the service caring?

## Our findings

Staff took the time to listen and observe people so that they received the care they needed. Staff had received specialist training in communication to support people to be involved in their care and remain as independent as they were able. People were relaxed in the company of the staff, and communicated with smiles and gestures. We saw that the staff used pictures or signs to support people with their communication needs to ensure they were consulted about their care. Two people were able to speak with staff and were supported to do what they wished, for example going out to the local park and looking at magazines.

Relatives told us they were involved in the care planning for their family member and were kept up to date with any changes in their care. Comments from a recent quality assurance survey stated: "We have only the highest praise for staff at Grosvenor Court. People are treated with courtesy, dignity and friendship".

People had received advocacy support when needed to make complex decisions, such as coming to live at the service or health care appointments. Records showed that Independent Mental Capacity Advocates, (IMCA) (an individual who supports a person so that their views are heard and their rights are upheld) had been involved in supporting people to make decisions in their best interests.

Staff asked people if they wanted to go into lunch before supporting them to move. During lunchtime some people were assisted to eat their meals. This was undertaken in a patient and sensitive way, whilst also engaging people in conversation. Staff made sure that people had appropriate cutlery, such as specialist spoons, plate guards and individual drink containers, so that people were supported to eat their meals as independently as possible.

People who were able were moving around the service and choosing where they wanted to be. Staff were seen asking people if they wanted to watch television and what channel they wanted to view. One person was transferred from a chair to a wheelchair, staff talked to the person being moved, explaining what was happening, using a quiet and reassuring approach. We observed that staff were attentive and understood when people used gestures when they needed to use the bathroom.

Staff told us that they came in to provide additional cover when people had health care appointments, so they could be supported by staff who know them well and would be able to help health care professionals understand their communication needs.

People were able to choose where they spent their time, for example, in their own rooms or in one of the lounges. People's family and friends were able to visit at any time. There were various rooms within the home, which relatives could be taken to for a private discussion.

We talked with health and social care professionals from the local community learning disability team who visited the home on a regular basis. They told us that staff treated people with respect and dignity.

The staff maintained people's privacy and dignity. Personal care was given in the privacy of people's own rooms or bathrooms. Care plans had information, such as "ensure privacy and dignity by closing doors, and using the screens when moving from bedroom to bathroom". People who required their medicine in private, were taken back to their bedrooms to maintain their privacy.

The registered manager told us they were was in the process of developing a new dignity tool, so that staff had detailed guidance to continually improve and respect people's dignity, and uphold their rights.

Requires Improvement

# Is the service responsive?

## Our findings

The registered manager told us that there was no formal plan for activities and these were decided on a daily basis. Health care professionals told us that the staff team were caring and people had their basic needs met, but were unsure if their social care needs were fully met. Due to the lack of staff people were not always receiving the support they needed for their one to one activities such as going out for walks and visiting the local shop. During the inspection people were not engaged in any activities, most people were in the lounge all day with the television or a DVD on. We saw records that showed there were some activities, such as massage sessions, bingo, music for health, and two people were also attending the local day centre. Although some activities were being provided there was no structure to demonstrate that people were receiving a full activity programme in line with their personal interests.

Relatives told us they were involved in discussions about their family member's assessments and care planning. The registered manager carried out a pre-admission assessment prior to a person moving in, to help ensure that the service would be able to meet their needs. Following assessment the staff developed care plans and these were personalised to reflect people's individual needs, such as sleep patterns, preference with regard to personal care and nutrition. Specific details were included, such as how pillows were to be placed and if a person liked to soak in the bath.

People's care plans had information about their backgrounds and family life. This helped enable staff to understand and talk to people about what and who was important to them. There was information about their choices and preferences and how they liked to be cared for. Records showed that relatives and/or health care professionals had been involved in review meetings to discuss peoples changing care needs. People's health care was monitored closely and there was detailed information to support people with their medical conditions, such as diabetes. There was guidance to show staff how they should respond if the person's blood sugar was too high or too low, and when to seek medical advice.

The service had responded appropriately when referrals to health care professionals, such as psychiatrists, speech and language and the community learning disability team, had been required. People' medication was being reviewed every six months to make sure they were receiving the medicine they needed. Relatives told us that the service responded promptly when their family member needed to see a doctor or any other health related appointments.

Relatives told us that they attended care review meetings and were kept up to date about their family member's care needs. One person commented on a recent quality assurance survey: "Excellent care and staff attitude, the manager always keeps in touch by phone". However not all care plans had been updated to reflect changes in peoples care needs. This shortfall had already been identified and was recorded in the service's improvement plan. The timescale for the registered manager to make the necessary changes was December 2014. Staff told us that they had detailed handovers between shifts, which kept them up to date with people's changing care needs.

Staff were observed asking people how they were feeling. There was also a monthly residents meeting where staff explained and talked about topics, using pictures to support people to understand the information. Records showed that people's views had been taken into account after the maintenance work had been completed in the garden. People were asked to walk round the garden to make any comments on the improvements. Quality assurance surveys had been sent to relatives so that they had the opportunity to voice their views about the service. A relative commented on a recent survey: "We are so pleased to see that a programme seems to be in place, to smarten up the garden area".

Records showed that people were being supported to have the equipment they needed to remain as independent as possible. Adjustments had been made to one person's wheelchair to make sure they had the correct support to make them as comfortable as possible.

Relatives told us that they did not have any hesitation in sharing any concerns with the staff or the registered manager, and were confident that the staff would deal with them.

Staff told us how they knew when people were unhappy. There were guidelines in the care plans to show how people would react by displaying certain behaviours when they needed reassurance or if something was wrong. The complaints procedure was also in a pictorial format so that people could be supported to make a complaint.

Requires Improvement

# Is the service responsive?

Complaints were recorded and investigated by the registered manager. There was a complaint recently about smells coming from the kitchen. Fans had been installed to address the issue, however this response had not been recorded in the complaints file, to show that the complaint had been addressed with a satisfactory outcome.

Requires Improvement

# Is the service well-led?

## Our findings

Records were not always up to date to reflect the care people were receiving. We found that there was some confusion by staff as to whether a person had stopped receiving physiotherapy. Records showed this had been discontinued, but at the time of the inspection staff were not able to clarify this information. After the inspection the registered manager sent us information to confirm this had been discontinued but the care plan and records had not been updated.

A shortfall identified during the inspection, was in the contents of a memo to staff to inform them that a person was 'grossly overweight' and details of what this person should have to eat at supper time, but there were no details in the care plan to promote a healthy diet for them. The wording in the memo was not respectful to uphold the person's dignity.

Records were stored securely and there were minutes of all meetings held so that staff and people would be aware of up to date issues in the service. We found that some records, such as care plans had not been reviewed regularly to show what updates had been made.

Records were therefore not accurate and lacked detail to reflect the care people were receiving.

This is a breach of Regulation 20(1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a registered manager in post who was supported by a deputy manager. People and their relatives knew the registered manager. One relative told us that the registered manager knew their family member well and was very knowledgeable about the service. Relatives also said that they would recommend the service. They felt that the organisation had 'got it right' and their family member was well looked after. They said they would definitely recommend the service and felt confident that any issues they raised would be addressed appropriately.

The registered manager was aware of the day to day culture of the service and observed staff practice when working as part of the team covering shifts and providing direct care to the people. During the inspection we saw the registered manager helping to move people with the hoist and supporting staff to meet people's needs. One member of staff told us that when they recently raised a staffing issue with the registered manager they promptly responded and addressed the issue.

Staff sat with people and encouraged them to communicate, using signs and gestures, such as smiling and pointing. Staff used the methods of communication reflected in people's care plans. Some people with complex care needs responded by smiling or communicating in the way they preferred. The atmosphere in the service was inclusive, with staff encouraging people to communicate with them and each other to help ensure people felt part of the conversations and daily routines in the service.

Staff and management were consistent and were aware of the organisations' vision and values. They told us that their role was to encourage people to be as independent as possible, provide them with choice and care, which was personalised to their needs. For example, at a recent residents meeting, it was noted that staff had tried to explain to people, it was their choice as to what staff member supported them. They suggested they would use pictures of staff so that people could decide. This was part of the organisation's new strategy "Inspiring People – Our Personalisation Strategy". The registered manager told us that they were booked to receive training on this personalised support, which had been designed by professionals and written by representatives of all levels within the company. The registered manager was also completing a teaching qualification to help enable them to cascade training effectively.

The registered manager had recognised the key challenges of the service and was taking action to manage these. For example, maintaining sufficient staffing levels to the assessed needs of people and sourcing additional funding to manage people with complex needs, who may require one to one staffing.

Staff had opportunities to voice their views on developing the service There told us they had the opportunity to raise issues with the registered manager at regular staff meetings, as well as individual one to one meetings and appraisals.

The organisation had systems in place to monitor the quality of the service. A representative of the organisation visited the service regularly to assess and check the quality of service being provided. The outcomes of these visits

Requires Improvement

# Is the service well-led?

were recorded and any identified actions and improvements were added to the service improvement plan. The last improvement plan review was carried out in September 2014, which highlighted the staffing levels issues, as well as staff appraisals not being carried out in line with the service policy at that time. There was an action plan in place to continue staff recruitment and for the manager to complete the staff appraisals by the end of November 2014. There were also indications of continuous improvement, for example the service was in the process of introducing "lessons learnt" which was an exercise to be completed following incidents to identify improvements and reduce the risk of further occurrences.

Regular audits had been completed on key elements of the service, such as the management of medication . These included ensuring that the gas, electrics and water checks for temperature were checked regularly, to help make sure that they working efficiently and were safe. This helped make sure any potential risks were managed and the quality of service provided continued to improve.

Staff told us that all policies and procedures had been reviewed and were now accessible through logging on to the service computer system. There were mixed comments about how easy staff would be able to access these, some staff said that it was not a problem, while others said it was not always easy to log onto the system. The registered manager told us that the organisation was in the process of providing another computer, so that staff would have better access to their systems.

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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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>The provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of staff on duty to fully meet the needs of the people using the service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br><br>Records were not accurate and lacked detail to reflect the care people were receiving. |