Renal Health Limited

Manor Lodge Care Home

Inspection report

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Date of inspection visit:
23 February 2017
27 February 2017

Date of publication:
10 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 and 27 February 2017. The visit on the 23 February was unannounced. This meant that the provider and staff did not know we would be visiting. Manor Lodge Care Home provides accommodation, care and support for up to 22 people with physical or mental health needs, or a learning disability. There were 14 people living at the home at the time of this inspection.

At our last comprehensive inspection of the service, in June 2015, we found four breaches of legal requirements which related to person centred care, safeguarding, safe care and treatment and good governance. We returned to the service in January 2016 and found the provider had made improvements to meet legal requirements.

A registered manager was 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.

At this inspection we found medicines were not managed safely. Two people had not received their medicines as prescribed as they were out of stock. In one case the medicine was a pain relief patch, which they had not received for three days. Whilst staff had contacted the pharmacy team to reorder the medicine, they had not sought medical advice about what steps they should take to ensure the person's pain needs were met whilst waiting for their regular medicine to be delivered.

Medicines were not always disposed of safely. Where people had not taken individual tablets these discarded medicines had been stored in a sharps box. There were no records as to what medicines were in the box, or when and how they would be disposed properly. Medicines records were not always accurate.

Staff had received training in safeguarding people from abuse, however, where one person made frequent allegations the process had not always been followed.

Accidents and incidents had been recorded, but were not monitored and analysed. Risks had been assessed and where possible, action had been taken to reduce the likelihood of the risks occurring again.

There were enough staff to meet people's needs. Staffing had recently been increased, whilst the home recruited additional staff they relied on agency staff. Robust recruitment procedures had been followed.

Staff training was up to date. The manager monitored essential training to ensure any refresher courses were booked before training expired. There were no formal assessments of staff competency. Whilst the training element of the care certificate had been taken into account for new staff inductions, the provider had not yet incorporated the assessment, feedback and reflective practice elements. Supervisions sessions were planned for staff to discuss their training needs and performance. We saw these were not always

regular. One staff member had not received any supervision since September 2016.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'.

The registered manager and staff understood the principles of the MCA. The registered manager told us that everyone who used the service was able to make their own decisions. Whilst we saw people were offered choice, and their decisions were respected, we saw one entry within care records which did not promote their rights.

Where restrictions on people's liberty were in place to keep them safe, applications had been made to the local authority to grant Deprivation of Liberty Safeguards in line with legal requirements.

People were very positive about the food on offer within the home. Most foods were home-made by the cook, who was knowledgeable about people's nutritional needs. A choice of food was available at every meal and food was on offer throughout the day.

People spoke highly of the staff team. Through our observations we saw staff were friendly and treated people with respect.

Care records contained a good level of detail about people's life histories so staff had an understanding of what was important to people.

Information was provided in a way which met people's communication needs.

Whilst information within care records was specific and detailed, it was not always up to date. Some people's needs had not been planned for. Staff had not been provided with information about how to respond to one person who frequently wanted to telephone for an ambulance. Where people's needs had changed care plans and assessments had not always been updated to reflect this.

Complaints records had not been well maintained. We saw one formal complaint had been received in the previous year, but we were unable to determine what action had been taken in response or whether the complaint had been substantiated.

Activities were on offer within the home, and the provider was purchasing transport to enable people to visit the wider community more frequently.

The provider did not have a robust system in place to monitor the quality of the service provided. The registered manager told us that checks were undertaken by them and the provider, however these were informal and there were no records of them. The provider's internal checks had not identified or addressed the shortfalls in medicines management and care planning which our inspection highlighted.

People, staff and health professionals were positive about the leadership in the home. They described the improvements they had seen in the service in recent months.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, person-centred care and good governance. You can see the action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines had not been properly managed. Some people had not received their medicines as prescribed. Processes were not in place to dispose of medicines safely.

Staff were trained in safeguarding, but records had not always been kept to show what action had been taken when people had raised concerns.

Agency staff were used frequently to ensure there were enough staff to meet people's needs. Safe recruitment processes had been followed.

Accidents and incidents were recorded, but not monitored to determine if there were any identifiable trends.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to equip them for their roles, however, formal assessments of staff competency were not carried out. Staff received supervision sessions with their manager, but records showed these meetings were not always held regularly.

The registered manager and staff were aware of the principles of the Mental Capacity Act 2005 (MCA). We observed people were offered choice.

People were supported to access services to promote their health and wellbeing.

People spoke highly of the food on offer. The cook was aware of people's nutritional needs.

Is the service caring?

Good

The service was caring.

People told us that staff treated them well and with respect.

Staff responded in a caring way when people were upset.

People were encouraged to be independent and their dignity was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst people's needs had been assessed, care plans did not always detail how staff should meet people's individual needs.

Complaints records had not been well maintained. We were unable to determine what actions had been taken in response to a complaint or low level concerns.

Activities were on offer within the home, and the provider was purchasing transport to enable people to visit the wider community more frequently.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor the quality of the service were informal and had not identified the shortfalls we found during our inspection, in relation to medicines and care planning.

Some records, in relation to the management of the service were poorly completed.

People, their relatives and professionals spoke highly of the registered manager.

Feedback had been sought from people and staff about their views on the service.

Manor Lodge Care Home

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 23 and 27 February and was unannounced. It was carried out by one inspector.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local authority contracts team and safeguarding adults team, and we contacted the local Healthwatch group. We used their comments to support our planning of the inspection.

We spoke with five people who used the service to discuss their views on the care and support they received. After the inspection we telephoned two people's relatives to obtain their views on the service. We talked with the registered manager, the provider's operational care director, the deputy manager, two senior support worker and two care workers. We also contacted one person's social worker and a member of the local NHS infection control team.

We spent time observing care and support being delivered in communal areas. We looked in the kitchen area, the laundry, bath/shower rooms, toilet areas and checked people's individual accommodation. We reviewed a range of documents and records including; three care records for people who used the service and three records of staff employed at the home. We also examined complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings with people who used the service and a range of other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People had not always received their prescribed medicines. One person was prescribed a pain relief patch which needed to be changed every 72 hours. We saw the person had not received their patch on one occasion as it had been out of stock. The person had not received this pain relief for three days until more of the medicine was delivered. Whilst we could see that staff from the home had contacted the pharmacy to order more of this medicine, they had not contacted NHS 111 for advice, to see if it could be sourced more quickly or if there were any other actions they should take. They had not contacted the person's GP to determine if they required any other medicines to manage their pain whilst their patch was unavailable. We saw another person had not received a prescribed nutritional supplement for 10 days as this had been out of stock. We fed this back to the registered manager who told us they would investigate why medicines had gone out of stock, and why staff had not taken action to ensure people's prescribed medicines were available to them.

Medicines were not always stored or disposed of appropriately. We found two tubs of food or fluid thickening powder were stored in an unlocked cupboard in the kitchen area used by people living at the home. Accidental ingestion of this prescribed powder can result in asphyxiation. The improper storage of this medicine put people at risk of harm. Where medicines had not been administered as prescribed, for example, if a person had refused their medicine, processes were not in place for safe disposal. We found a large number of tablets which had not been administered were stored in a sharps box within the medicines room. This meant any staff member with access to the medicines room could access these tablets. There was no record kept of how many tablets had been discarded into the sharps box to be disposed of. We fed this back to the deputy manager on the first day of our inspection and she sourced a suitable method for the disposal of loose tablets, which was in place by the second day we visited.

Records related to medicines were not always well maintained. Some people were prescribed controlled medicines. Controlled drugs are medicines which are liable for misuse, and therefore stricter storage and recording controls are needed. We reviewed the records relating to controlled drugs and found discrepancies between the number of medicines in stock and the number recorded. We determined these discrepancies were the result of miscalculations when new stock arrived in the home. However, this showed staff were not following the controlled drug policy of counting stock at each administration.

Some medicines administration records were handwritten. We saw that there had been no check by staff to ensure these handwritten entries fully reflected the information contained on medicine labels. Some of the handwritten MARs were also undated. We saw one person's medicines had been changed by their GP from a daily prescribed medicine to a medicine to be given 'when required'. We saw their MAR had not been updated to note this change. No instructions had been provided to describe how staff would be able to identify that this person 'required' this medicine. This meant the person could be at risk of receiving inconsistent care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had undertaken training in identifying and responding to safeguarding concerns. We spoke with four staff who were able to explain the process they would follow if they had any concerns of a safeguarding nature. Staff were aware of their responsibility, and told us they were confident that the manager of the home would respond to any concerns appropriately. People told us they were happy living at the home. One person said, "It is a safe place." A relative confirmed this saying, "It's safer now than what it used to be. At one time I was concerned. But the number of incidents (altercations between people who used the service) has reduced." We saw from one person's records that they made frequent allegations against staff or other people who used the service. Their care manager was aware of this, and the registered manager informed us that each allegation was considered to determine if it was factual. However, there was no record of some of these considerations. Some concerns had not been included within the safeguarding log, and in these cases it was difficult to determine from records what, if any action, had been taken.

We recommend that the provider ensures any allegations of a safeguarding nature are recorded detailing the assessments and considerations which have taken place.

Risks related to people's care needs had been considered. For example any risks related to using specific equipment or the risk a person may develop pressure damage. Information was provided to staff about the steps they should take to mitigate these risks. Accidents and incidents had been recorded. Staff had completed records prompting them to detail how any accidents or incidents had occurred, and the way they had responded. The registered manager had reviewed these to check staff had responded appropriately. The registered manager did not monitor or analyse accidents and incidents information, in order to determine if there were any trends in accidents or incidents across the service. She told us she was in the process of introducing new monitoring forms to review accidents on a monthly basis to determine if any further action needed to be taken.

Steps had been taken to ensure the building and any equipment used was safe. The call bells and fire alarms were tested weekly. Equipment such as hoists, boilers, and lifts were serviced regularly so they were kept in good working order. Window restrictors were in place and checked regularly to ensure any risks were minimised. Specialist companies had assessed the risk of asbestos or legionella and the home was found to be meeting the required standards. We noted an electrical installations check had last been carried out in June 2013, and the recommended retesting date had been set for three years. This retesting had not been arranged. We fed this back to the operations manager for the provider who advised us he would arrange this testing as soon as possible.

Processes were in place in case of an emergency. An information sheet was available for each person who used the service in case they needed to be admitted into hospital. These sheets provided hospital staff with details about the person's moving and transferring needs, communication needs and regular prescribed medicines. Each person had a personal emergency evacuation plan (PEEP) which set out what assistance they would require in the event of the home requiring to be evacuated.

There were enough staff to meet people's needs. Three staff were on duty during the day, and two staff on duty overnight, to support the 14 people who were cared for at the home. People we spoke with told us staff responded to them quickly if they needed support. We observed that staff were unhurried and had time to sit in the lounge with people and support them with activities. The registered manager had recently increased the daytime staffing number from two to three. She told us she did not complete any formal assessments to determine staff numbers, but based the staffing on how much support each individual person needed.

We noted from feedback from people who used the service, staff and relatives, in addition to reviewing the

staffing rotas, that there was a high number of agency staff working in the home. Staff rotas showed that within one month of our inspection there were eight occasions where two of the three staff on duty were agency staff. The deputy manager advised us that they tried whenever possible to use the same agency staff so people who used the service got to know them and so consistency of care was maintained as much as possible. The deputy manager also told us the home were in the process of recruiting additional care staff which would reduce the need for agency staff.

Safe recruitment practices had been followed. We reviewed three staff files. There were records of application forms, interview notes and identity checks. Two satisfactory references had been sought before staff had commenced work, including one from a previous employer. All staff had an enhanced Disclosure and Barring Service (DBS) check in place. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for their role.

The registered manager told us about the renovations which had been undertaken since our last inspection. Flooring throughout the home had been replaced, new bathrooms had been installed and a kitchen area had been put in place so people could make drinks and snacks for themselves. The home was clean, tidy and there were no malodours. We noted that some of the bins within the home did not have foot pedal operated lids, and some of the light pulls were not covered in plastic casing. We fed this back to the registered manager who told us she would address these areas.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us that staff were skilled and "did a good job". One person said, "They [staff] are fine. They know what they are doing. I can't think of anything they need to get better at." We spoke with one person's care manager who told us, "The staff are well trained. I haven't always thought that, but they are making improvements. Over the last year they have changed lots of the staff team. They seem to be getting new staff up to speed in everything they need to know."

Newly employed staff attended five days of induction training which covered the skills they required for their role, such as moving and handling, communication and health and safety. This training was delivered face to face, and had been designed to meet the requirements of the Care Certificate. The Care Certificate details the learning outcomes, competences and standards of behaviour that are expected of an adult social care worker, to ensure staff are caring, compassionate and provide quality care. Whilst staff received training, we noted there was no record of staff competency checks or reflective practice, where care staff could consider their learning needs and discuss these with their manager. We discussed this with the registered manager and the deputy manager who advised us they were in the process of implementing more formal supervisions and assessments during the induction period.

We reviewed staff training records, and saw there was an on-going training program to ensure staff skills remained up to date. The registered manager kept an overview so she could monitor when staff refresher courses were required. Staff we spoke with confirmed training was provided to them. One staff member said, "We get whatever training we require." Another staff member said, "We get face to face training, and some of it is done through Care TV (video based learning), [Registered Manager] is always putting new notes for us about updates, new guidance or whatever it is that we need to familiarise ourselves with." Whilst we saw staff received this training the registered manager did not carry out any documented assessments to ensure staff had the skills and knowledge they required to carry out their roles.

The registered manager told us she aimed to meet with care staff "every couple of months" in supervision sessions to discuss their role, performance and the needs of people who they supported. Supervision sessions showed that these meetings were sometimes irregular. We saw some staff had met with their manager every three months, however another staff member whose records we looked at, had not attended a supervision session since September 2016. Staff we spoke with told us they could speak with their manager whenever they needed to. The registered manager told us that she had held yearly appraisals with staff who had worked at the home for over 12 months, to discuss their performance and any training and personal development needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedures for this in care

homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff had a good understanding of the Mental Capacity Act (MCA) and their responsibilities to ensure people's rights were upheld. Training had been completed in this subject. The registered manager told us that people who used the service had capacity to make all of their own choices, and were encouraged by staff to do so. We noted information within one person's care plan gave staff instruction which did not evidence this. It said, "[Person's name] needs to be regularly toileted throughout the day, whether she states she needs to go or not …" We discussed this person's needs with staff and the registered manager who assured us that the person was prompted and given encouragement as opposed to being taken against their will. We discussed that the way the care plan was written might not provide staff with accurate information about this person's capacity and their right to make choices, which may put the person at risk of their rights not being upheld. This was particularly important given the high use of agency staff within the service. The registered manager told us she would arrange for the care plan to be rewritten as soon as practicable.

Care records contained copies of consent documentation, signed by people. People had given permission for the home to share information with key professionals and permission to have photographs taken and displayed within the home. During our inspection and from daily records, we saw that staff respected people choices; such as if they wanted their medicines or not, if they wanted to attend medical appointments and where they wanted to spend their time within the home.

We checked whether authorisations had been sought if people's liberty was deprived to keep them safe. The registered manager told us a DoLS application had been made to the Local Authority in line with the principles of the MCA for one person whose freedom was restricted. The application was in the process of being assessed. We spoke with staff who were aware that only one person who used the service had any restrictions placed on their movement to keep them safe. People who used the service, relatives and staff confirmed that people were able to come and go from the home as they wished. We were told that people regularly went into the local town unaccompanied.

People spoke very highly of food on offer at the home. One person said, "I had sausage casserole today and it was lovely." People had access to a kitchen area so they could make their own refreshments and snacks. The service had a 5* hygiene rating from the local authority which was displayed on the wall. We spoke with the cook who was knowledgeable about people's nutritional needs. Where people were underweight their food was fortified to provide them with additional calories. Milkshakes were prepared as a high calorie snacks for people. The cook told us that all of the meals in the home were home-made. During our inspection we saw people were offered freshly baked pies, scones and fruit crumbles.

The cook told us that they had access to a wide range of fresh fruit and vegetables, and that the budget they were provided with was adequate to provide a range of nutritious food to people. We noted the menu on display was out of date, but we were advised the cook was creating a new menu which would include pictures to aid people's understanding. If people did not want any of the options on the menu, they could choose from a range of other items. On one of the days we were inspecting, in addition to the two options on the menu, the cook was also preparing an omelette for one person who had requested it.

Where people needed support to eat, staff sat beside them, giving them their full attention and chatted with the person whilst they helped them with their meal. We noted that the atmosphere in the dining room was very relaxed and people appeared to enjoy their meal experience.

People accessed a range of external health and social care professionals to maintain their general health

and well-being. We found evidence that staff had communicated with GP's, specialist nurses and social workers, and they had made hospital appointments when necessary. Detailed notes were kept of all interactions with healthcare professionals and any follow up actions were noted and had been put into place.

Since our last visit many of the communal areas of the home had been renovated. Improvements had been made to the bathrooms, one of which had been turned into a shower room so it was more easily accessible for people with mobility needs.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at the home and that they were treated well by staff. People's comments included; "The staff are nice," "It's good," and "They're (Staff) canny." Relatives told us that staff were friendly and welcoming when they visited the home. One relative said, "The girls are lovely. The staff are excellent. They are very good." Another comment from a relative was, "Some of them bend over backwards to help [Name of Person]."

Throughout our inspection we observed that people who used the service and staff appeared to enjoy a friendly and light-hearted relationship. They shared jokes and seemed relaxed in each other's company. Staff talked with people about their plans for the day, activities they were taking part in, and their hobbies. Staff appeared to know people well. During our inspection we noted one person became upset. Staff were caring in their response. We saw they spent time sitting next to this person and asking them questions to determine why they were upset. A staff member got this person a cup of tea and checked they were feeling better before they returned to their other tasks.

Staff treated people with dignity and respect. Staff told us, and records confirmed, that people's dignity was considered when care was planned and delivered. Staff told us how they were mindful of people's dignity when they provided personal care. We saw staff knocked on people's bedroom doors and waited for a response before they entered.

People's independence was promoted. Care records were clear about the tasks each individual was able to complete independently, and gave information for staff to encourage and support people to take part in as much as they could for themselves. For example, tidying their room, or completing some parts of their own personal care. People had access to washing machines to launder their own clothes if they wanted to, and to a kitchen to prepare drinks and snacks. People and relatives told us that people were supported to be independent. One relative said, "We were there once and we saw them (staff) try and teach [My relative] to do things for herself."

People were involved in their care. Care records were very detailed in respect of people's personal preferences around the things they liked to do, daily routines and whether they would prefer their care to be provided by male or female staff. Each person's care records included a comprehensive life history, which gave staff an overview of their upbringing, occupations, and family life. These records enabled staff to understand what was important to the person.

Where possible people's assessments and plans of care had been signed by them to show they agreed with what was written. The home had introduced a key worker system where a particular member of staff was responsible for discussing people's care with them on a monthly basis, and reviewing and updating care records. Records from these meetings showed they had been held infrequently. The registered manager told us that due to recent staffing changes, some keyworker meetings had not taken place where some key workers had left the organisation. She told us that as more permanent staff had recently been recruited, she would ensure these were carried out on a monthly basis in the future.

Information had been provided in a way which met people's communication needs. The service user guide, which included information on what people should expect from the service and how they make a complaint if they needed to, included information in pictures to aid people's understanding.

The registered manager told us that at the time of our inspection no one was accessing an advocate although this could be arranged, if required. Advocates represent the views of people who are not able to express their wishes themselves.

Requires Improvement

Is the service responsive?

Our findings

Care had not always been planned to meet people's needs. One person frequently called the emergency services. We saw from records that a staff member had agreed with a representative from the North East Ambulance Service that they would advise call handlers, "whether an ambulance was really needed". When we fed this back to the registered manager she told us she was unaware that staff had made this agreement. We saw from records that on one occasion staff had refused this person's request to call an ambulance, and the person had left the home to use a nearby phone box. When we spoke with staff they told us they would advise call handlers whether the person did need emergency support. One member of staff said, "We'll tell them whether we think it's really needed. More often than not though they will still send a paramedic crew if they have one available." We saw there was no care plan in place to provide staff with the information about how they should support this person when they said they needed to telephone for an ambulance, or how staff should respond to call handlers requests about whether the person was in need of emergency healthcare.
In discussions the deputy manager told us it was very difficult as staff from the home felt pressured by staff from the ambulance team. The registered manager acknowledged that this need had not been addressed within the care plan. Staff had not been provided with any information or tools they could use to inform call handlers of specific information about the person's presentation. This meant this person was at risk of inconsistent care which did not meet their individual needs. In addition, one person made frequent allegations about other people who used the service or staff. There was no information within their care plans about how staff should respond when such allegations were made.

A range of assessments had been carried out, and where needs were identified care plans gave staff instruction about how to meet those needs. We saw assessments and care plans were reviewed monthly, however when people's needs changed these documents had not always been updated. We saw one person had begun to refuse one type of medicine, but their care plan and assessments described them as being compliant with all medicines. Incident records showed one person had been admitted into hospital after taking an illegal substance. There was no care plan or assessment in place to determine if this person needed any support to reduce the likelihood of such an incident reoccurring.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014, entitled Person-centred care.

Whilst we identified these shortfalls in some people's records, we did note that other care plans in place were specific to the individual and detailed.
People and relatives we spoke with told us staff were responsive to their needs. Their feedback included; "The staff know [my relative] very well;" and "We're very happy with the care provided."

Activities were planned in the home for people to take part in. The registered manager told us there was a weekly programme of crafts, pamper sessions, quizzes and light gardening. People we spoke with told us they were happy with the activities on offer. One person said, "There is enough going on. I don't often take part, but could if I wanted to." Staff accompanied some people into the local town, to go to the shops or for

a trip to the hairdressers. The results of the last satisfaction survey showed that one person had expressed they felt there was not enough to do. We discussed this with the registered manager who told us that part of the reason for increasing the staffing levels during the day was to ensure there was enough time to provide meaningful activities for people. They also said, "What is wanted is regular trips out. But, that comes at a cost and there is no additional funding available to us for that. The company (provider) are going to meet that cost." The registered manager told us that the provider organisation was buying a people carrier which would be shared across three of the homes they owned. She told us this would mean it would be easier to take people out in groups to visit places or go to events."

People we spoke with told us they knew how to make a complaint, but advised us they were happy with the service they received. One relative said, "I've never had to make a complaint, but if I did I would try to go to them (staff) and resolve it first."

We reviewed the complaints records and saw there had been one formal complaint in the previous year. We saw the original communication from the complainant, and staff statements in response to the concerns, however, we were unable to view the outcome of the complaint, or to see what response the complainant had received. The registered manager told us she had written to the person making the complaint, but acknowledged that records did not show if the complaint was substantiated or if any actions had been taken to improve the service following the complaint. We saw two low level concerns had also been raised with the registered manager, but again no records had been kept to show what the outcome was. The registered manager told us that she had sourced a new complaints log, which prompted staff or management dealing with any complaints to record specific information to enable reflection and improvements to be undertaken following any complaints. She told us that moving forward she would ensure records related to any future complaints were better maintained.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. She had been formally registered with the Care Quality Commission in April 2016. The registered manager was present on the second day of our inspection and assisted us with our enquiries. The registered manager was also in charge of the day to day management of another of the provider's services located nearby. She was supported by an operational care director employed by the provider to oversee the management of the provider's services, and a deputy manager.

During our inspection we found shortfalls in the management of medicines and established that care had not always been planned to meet people's needs. The provider's system of monitoring the quality of the service provided was informal, and had not identified or addressed the concerns which we had found. We asked the registered manager what checks they carried out to assess the quality of the service. They advised us they monitored the environment on a daily basis, chatted with people who used the service to ensure their satisfaction, and observed staff practice, providing any feedback immediately and in an informal way. However, there were no records of these checks.

We were told a medicines audit was carried out on a weekly basis, however when we reviewed these records we saw they were simply a check of medicine stocks. We were not shown any evidence that medicines records, administration or disposal processes were monitored or assessed. The medicines audit in place within the service did not prompt staff to assess how medicines were handled in a way which would identify the shortfalls which we found. We looked at care plan audits, and saw four people's care records had been reviewed in the previous year, to ensure they were complete and met people's needs. This meant no formal checks had been carried out by the manager or the deputy to ensure the remaining ten people who used the service had care plans which met their needs.

Maintenance records showed that action had been taken to improve the environment when any issues had arisen or been raised. However, there were no records available to show the assessments in place to monitor health and safety or infection control within the home.

Records relating to the monitoring of safeguarding allegations, complaints and accidents and incidents were poorly maintained. They did not always show what action had been taken to address any concerns identified.

The provider's operational care director visited the home frequently. We saw meetings were held monthly to discuss the home's performance and any issues which were raised by the operational care director or the registered manager. However, any assessment of quality or feedback by the operational care director was done informally. The provider did not carry out any quality monitoring audits or provide written feedback following their visits. This meant the provider had
failed to implement an effective system to assess, monitor and improve the quality of the services provided.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014, entitled Good governance

We fed back our findings on the systems to monitor the quality of the service which was provided, and the operational care director and registered manager told us they had identified that they needed to strengthen their auditing systems. They told us they had recently purchased a software tool which would provide the service with a schedule of audit to assess their service. They also told us they were making changes to the staffing structure to ensure the registered manager had more time to spend on these quality checks.

The registered manager and the operational care director had extensive knowledge and experience of working with people with complex mental health needs and / or a learning disability. All of the people who used the service, and the relatives that we spoke with were aware of their names, and told us they were a visible presence in the home. During our observations we saw that people appeared comfortable with the managerial team, and chatted with them about what their plans for the day were, or how they were feeling.

We spoke with two health and social care professionals who told us the registered manager and provider continued to make improvements within the service. One said, "It is much improved. They've taken on board our feedback and done what we've asked. They responded positively to our advice." Another told us, "Over the years they have tried to improve. They have worked on the culture at the service and the overall feel."

Staff we spoke with told us the management team were supportive, and that their opinion on the service was sought and respected. Staff attended regular meetings to discuss changes within the home and employment issues. The registered manager told us she had an 'open door' policy, and staff we spoke with confirmed that they could speak with her, or the deputy manager whenever they needed to. The provider's website stated, '[The Home] supports individuals to maximise their independence'. Staff we spoke with confirmed that this was one of their main aims. One staff member said, "Our whole purpose is to help people to live their life as they want to. We aren't here to stop them from doing anything. We help them."

Feedback had been sought from people who used the service, staff and visiting professionals. Surveys issued to people who used the service had last been sent out in January 2016. These had included some images to aid people's understanding. The majority of the responses returned had been positive. Relatives we spoke with told us that they had never been asked to complete a survey or give written feedback on their experience of the service. The registered manager told us that they planned on including relatives, when the next group of surveys were sent out.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always appropriate and did not always meet people's needs or reflect their preferences. Regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided safely. Systems were not in place to ensure the proper and safe management of medicines. Regulation 12(2)(f)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to assess, monitor and improve the quality and safety of the service provided were not robust to identify and address shortfalls. Regulation 17 (1)(2)(a)(c)(d)(f).