Voyage 1 Limited

Pelham Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 21 June 2016. The inspection was unannounced. Pelham Lodge provides accommodation for up to nine people who have a learning disability. There were six people living at the service on the day of our visit.

The service had a registered manager in place at the time of our inspection. 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.

Risks in relation to people's care and support were not always assessed or planned for appropriately. Risks in relation to the external environment were not managed appropriately and the service was not clean and hygienic in all areas.

There were not always sufficient numbers of staff available to meet people's needs. Safe recruitment practices were not always followed.

People were supported by staff who knew how to recognise abuse and how to respond to concerns and there were systems and processes in place to protect people from abuse. Medicines were managed safely and people received their medicines as prescribed. People were supported to eat and drink enough and had their healthcare needs met.

People's rights under the Mental Capacity Act (2005) were not always respected and applications were not always made where it was likely that people were being deprived of their liberty. However, people were involved in making decisions about their care and support and were supported to make day to day decisions.

People's diverse needs were not planned for. People were not always treated with dignity and their right to privacy was not always respected. People's communication methods were not consistently recognised or acted upon appropriately by staff.

People were supported by staff who were provided with training and supervision.

People did not always receive consistent support as support plans contained out of date information and some support plans had information missing. Staff did not always have knowledge of people's preferences. However, people were supported to have a social life and to follow their interests.

There were systems in place to monitor and improve the quality of the service provided. However they were not always effective in identifying areas for improvement.

The management team were open and approachable. People were supported to raise issues, concerns and complaints and felt assured that these would be dealt with appropriately. People were given the opportunity to get involved in giving their views on how the service was run.

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.

There were not always enough staff to meet people's needs. Safe recruitment practices were not always followed.

Risks in relation to people's care and support were not always assessed or planned for appropriately. Risks in relation to the external environment were not managed appropriately.

The service was not clean and hygienic in all areas.

People were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

People received their medicines as prescribed and medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People made decisions in relation to their care and support. However, people's rights under the Mental Capacity Act 2005 were not always respected.

People were supported by staff who received training and supervision.

People were supported to eat and drink enough.

People had access to healthcare and people's health needs were monitored and responded to.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's diverse needs were not planned for and their dignity was not always respected. People's right to privacy was not always respected.

People's communication methods were not consistently recognised or acted upon appropriately by staff. Staff did not always have an understanding of people's preferences.

People were involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive consistent support as support plans contained out of date information and some support plans had information missing.

People were involved in planning their care and support. People were supported to have a social life and to follow their interests.

People were supported to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to monitor and improve the quality of the service were not always effective.

Areas for improvement were not always acted upon swiftly to ensure people's safety.

The management team were approachable. People were involved in giving their views on how the service was run.

Pelham Lodge

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.

We inspected the service on 21 June 2016. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service. 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.

During the visit we spoke with five people who used the service and the relatives' of two people to get their views. We spoke with three members of support staff, the care manager, the acting deputy manager and the registered manager. We looked at the care records of five people who used the service, medicines records of four people, staff training records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and registered provider.

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.

Requires Improvement

Is the service safe?

Our findings

People did not always receive the care and support they needed in a timely way as there were insufficient staff on duty to meet people's assessed needs. One person who had complex needs required one to one support to keep themselves and others safe. This person was not usually at the service during the day, however on the day we inspected the person returned early and there were not enough staff in the service to provide one to one support. The acting deputy manager told us that happened very frequently and this placed a strain on the staff. We spent the day in communal areas and we observed that throughout the morning and early afternoon the main lounge area was chaotic and there was no structure to how people spent their time. The person who needed one to one support was left unoccupied for long periods of time and behaved in a way that impacted upon other people. One person who was enjoying an activity said, "Please be quiet [person]." In the afternoon when there were staff available to provide one to one support. The person was noticeably calmer and was occupied by the member of staff. This also had a positive impact on other people using the service.

The insufficient staffing levels also had an impact on other people using the service. One person who was known to place themselves at risk of self-harm became visibly distressed for periods throughout the morning. We observed the person display self-injurious behaviour and there were no staff in the vicinity to support the person. This meant the intervention described in the person's care plan when they presented to self-harm was not followed because there were not the staff available to do so and the person continued to self-harm. Additionally, one person had been assessed as needing two staff to support them with personal care. We identified occasions during our visit where the person was being assisted with their personal care by only one member of staff. This put the person and staff at risk of harm.

We spoke with the care manager about this who acknowledged the impact this was having on people using the service and they told us that they had contacted the local authority to try and secure increased funding. However the provider had not taken any action in the interim to ensure a member of staff could be available to support the person and reduce the impact upon others.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to individuals were not always assessed and planned for to ensure staff had access to information about how to manage these risks. For example one person was at risk of choking and we were told by the deputy manager that this person now had special diet to reduce this risk, however there was no risk assessment in place related to this and no clear plans in place detailing how staff should manage the risk. We also saw that this person had a fortified drink to reduce the risk of weight loss; this also was not stated in their support plan. Although staff who worked permanently in the service were aware of how to support the person, there was a risk that new or agency staff would not have the information needed to minimise the risk of the person choking or losing weight.

People were not always supported to move and transfer in a safe way. We saw one person receive unsafe

support with their mobility. Additionally the person's care plan specifically stated the person should not receive the support in the way we observed it to be provided. This put the person and staff at risk of harm as a result of unsafe moving and handling practices.

People were not always protected from the risk of falls. The acting deputy manager told us that one person was at high risk of falling, in particular, from their bed and we saw records that the person had fallen multiples times. There was no specific risk assessment in place to assess the level of the risk and the controls in place to prevent the person falling from their bed were not detailed in the support plan. We spoke to a member of staff who told us that a staff member sits next to the person's bed throughout the night to prevent them falling from their bed. This was an unsafe method of preventing falls as it put the person and staff at risk of harm should they try to catch the person or break their fall. We spoke to the care manager about whether alternative control measures had been considered and they informed us that a crash mat had been recommended by an external health professional, however this had not yet been provided.

People were put at risk because plans made to keep them safe were not always followed. For example a plan had been put in place to prevent one person leaving the building alone in order to keep them safe. During our visit we saw that this plan was not being followed. This put the person at risk of harm should they leave the building unescorted.

People were at risk when accessing the garden area as this had not been safely maintained. This created a risk that people could trip and fall due uneven flagstones and overgrown plants and weeds. Additionally there were further trip hazards with old broken garden furniture and other items left on the patio area. The acting deputy manager told us that people did not use the garden, however on the day of our inspection we saw people were doing so.

People may be supported by staff who may not be fit and safe to do so because the registered manager had not taken all of the necessary steps to ensure staff they employed were of good character. Two staff files did not contain all the details required about the staff member's previous employment. Before staff were employed the registered manager carried out checks to determine if staff were of good character and requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

We found that not all areas of the service were clean and hygienic. Staff had completed daily task sheets to state they had cleaned all areas of the service on a daily basis. However we found the dining room floor and tables were sticky and unclean. We observed an infection risk in one person's bedroom which was not attended to throughout our visit. Carpets were dusty and soiled and there were smears on windows and door handles.

People were given their medicines as prescribed by their doctor. People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them.
We found the medicines systems were organised and that people were receiving their medicines when they should. We saw examples of medication administration records (MAR sheets) that had been completed correctly by staff with details of medicines people had taken and creams that had been applied. A MAR sheet is a document showing the medicines a person has been prescribed and recording when they have been administered. Each person had a medication profile detailing how they preferred to take their medicines and a record of any allergies. There were protocols in place for 'as required' medications. Staff were following safe protocols, for example completing stock checks of medicines to ensure they had been given when they should. Staff had been trained in the safe handling and administration of medicines and had their competency assessed annually to make sure they were keeping up to date with good practice.

Medicines audits were carried out monthly to ensure medicines were being managed safely and people were receiving their medicines as prescribed.

There were systems and processes in place to protect people from abuse and avoidable harm. Relatives we spoke with said they felt their relations were safe in the service. One relative told us, "[Relation] is definitely safe." People were supported by staff who recognised the signs of potential abuse and how to protect people from harm. Staff told us they had not witnessed any poor practice and one said, "I've never seen anything here, I can whistle blow." Staff had received training in protecting people from the risk of abuse and staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm and to escalate concerns to the management team or to external organisations such as the local authority. One member of staff told us "I would tell my manager straight away…if they didn't do anything I would go straight to CQC." Staff were confident that any concerns they raised with the management team would be dealt with straight away.

People were protected from risks associated with the environment of the home. We saw there were systems in place to assess the safety of the service such as fire risk and the risks of legionella. Staff had been trained in relation to health and safety and how to respond if there was an emergency in the service.

Requires Improvement

Is the service effective?

Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People could not always be assured that their rights under the MCA would be respected. Although the staff and management team had an understanding of the principles of DoLS we saw that there were two people whose care and support was a deprivation of their liberty without the appropriate authorisations being in place. Staff we spoke with and the acting deputy manager described how one had their freedom restricted when they became very agitated which resulted in them not being free to leave the service. We looked at care records which confirmed that this was the case. This decision had been made in the person's best interests in 2013; however it had not been recently reviewed. A new ruling had since been passed by the Supreme Court and it should be established if this person was now being restricted without the authorisation to do so, but the provider had not ensured a further application was made to the local authority.

A second person had restrictions placed upon them and had their rights to privacy removed. We were told by staff that this person was always within the line of sight of a member of staff and never had any time alone due to the risks associated with their care; this was also documented in their support plan. This person was being deprived of their right to freedom and privacy without the required authorisation being applied for. An application had not been made to the local authority to have the person assessed and so these restrictions had not been authorised. We spoke to the care manager about this, who was unaware that the above people's care and support was a deprivation of their liberty. The care manager took immediate action to make DoLS applications for both people.

Throughout our visit we saw staff offering people choices and supporting day to day decision making, for example one person was supported to make a choice about what they ate for lunch by staff who showed them the food packaging to help inform their choice. We saw there were support plans in place informing staff on how to assist people to make their own decisions. For example in one person's support plan there was information about which times of day and under what circumstances the person would be most likely to be able to make decisions for themselves.

We also saw where a person's capacity had been assessed for specific decisions, such as independently

managing their finances, and it had been deemed they lacked the capacity there was a MCA assessment in place showing how the person's capacity had been assessed and detailing the decision which had been made in their best interests.

People were supported by staff who had supervision and support. Staff we spoke with told us that they felt supported and they had had recent supervision meetings. One member of staff we spoke with told us that they felt well supported, they said "I've been through a hard time and the managers have been brilliant and easy to talk to." The management team had identified supervision as an area for further improvement and told us in the PIR that they planned to train senior staff to take on staff supervision.

People were supported by staff who had received appropriate training. Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. One member of staff told us "we get lots of training, we had training in epilepsy and if you have not had this you are not allowed to support [resident]." We saw records which showed that staff had up to date training in a number of areas including equality and diversity, first aid and fire safety. We also saw that staff had training relating to the specific needs of people using the service such as MAPA training. MAPA is a technique for working with people who communicate with their behaviour to ensure that people are protected from harm. Staff we spoke with were knowledgeable about the systems and processes in the service and about aspects of safe care delivery. Staff were provided with an induction period when starting work at the Pelham Lodge. The registered manager told us in the PIR that new staff complete mandatory training in the first few weeks of employment and they also spend time shadowing more experienced staff members to learn about the needs of people using the service.

People who sometimes communicated through their behaviour had support plans in place informing staff how to spot the triggers and how to respond. A behavioural therapist was employed by Voyage and had been working on developing care plans for people who sometimes communicated through their behaviour. The records for one person showed the behavioural therapist had developed an in-depth care plan detailing what may trigger certain aspects of the person's behaviour. This care plan gave guidance on how staff could avoid the triggers and how they should respond if the person's behaviour escalated.

People were supported to eat and drink enough and had their weight monitored on a regular basis so that any changes could be identified. One relative told us, "They (staff) appear to be good with regards to food and drink." Records showed one person had some unplanned weight loss and staff had sought advice from the person's GP which had led to a referral to a dietician. Staff had supported the person in line with the dietician's recommendations and this had a positive impact with monthly weight records showing the person was gaining weight. Another person had health risks in relation to their weight and staff had sought advice and had implemented a healthy eating plan and the person was being supported to achieve a healthier weight. One member of staff we spoke with described how they supported this person, saying, "We give [name] a varied diet, we watch what [name] eats and we help with portion size".

People were supported with their day to day healthcare needs. One person was supposed to wear specialist shoes due to a risk of falls. Records showed the person did not like wearing these shoes and staff had gone to great lengths to change the colour of the shoes to the person's favourite colour. This had still not worked and so the person had new shoes in their favourite colour made. Staff had then recognised the person would only wear these outdoors and so were in the process of having slippers made to encourage the person to wear specialist footwear all of the time.

People were supported to attend regular appointments to get their health checked. One relative told us,"[Relation] goes to the dentist regularly, sees the doctor and the nurse." Records showed people were

supported to see the dentist and optician on a regular basis and one person had regular appointments with a podiatrist. People had their healthcare detailed in their care plan and there was a support plan detailing how each person should be supported to attend health care appointments. Staff told us there was a system in place to ensure people received healthcare support. One member of staff told us, "Doctors or dentists are all sorted by the seniors. Details are put on the board in the Meds (medication) office and at the start of shift we check the board."

The building had been recently decorated and the acting deputy manager told us that they were currently deciding upon furnishings. One room had been allocated as a sensory room and work had started to develop this. The acting deputy manager told us that this had been discussed and agreed with people living at the home. We saw that one person enjoyed spending time in a quiet communal area, this person told us that it was their space and we saw that others respected this. The manager told us that they were doing further works to improve the environment, they had ordered new furniture for communal areas and for peoples rooms and they had plans for people from another service to come and work on the garden.

Requires Improvement

Is the service caring?

Our findings

People's diverse needs were not assessed or planned for. In the PIR the registered manager told us there was one person who used the service who had support needs regarding their individuality and how they chose to express this. We looked at this person's support plan and there was no evidence of this being considered and no information available for staff on how the person should be supported with this.

One person belonged to a different culture from other people who used the service but there was no support plan in place detailing the aspects of the person's care and support in relation to their culture. The person was supported to attend a group to meet with other people from this culture; however, there was no other evidence of how this person was provided with culturally appropriate care. A member of staff said they had, some time ago, offered the person culturally specific food choices and the person had declined this. We asked the person about if they wished to be provided with culturally specific food now and they and they told us, "I would probably try it now."

People's dignity was not always respected. Although we saw examples of staff being kind and compassionate to people we also heard staff referring to people in an infantile manner. For example on a number of occasions we heard staff say to people, "That is naughty" and "Don't be naughty." We also saw that people's support needs were described in an authoritative manner such as, "Do not allow [name] to leave the bathroom in a mess." Support plans did not always promote dignity for example one person had a suffered a family bereavement over six months prior to our inspection. We looked at this person's support plan and saw that the plan had a series of lines through the relative's name who had passed away. This was not respectful of the person's dignity and did not demonstrate a caring approach to support planning.

One person needed support with their continence and this had been known by the care manager for approximately six months. Although the issue had been identified the person had not been provided with appropriate support in a timely manner. This had led to avoidable incidents of incontinence in public areas and in the community and staff told us this also significantly disturbed the person's night time routine, with the person being supported to change clothes multiple times throughout the night. This did not respect the person's dignity. Although the care manager explained that a referral had recently been made to an external health professional for support, the management team had not taken swift action to resolve this issue and the preserve the person's dignity.

People's right to privacy was not always respected. We saw that two people did not have blinds or curtains up in their rooms. The acting deputy manager told us this had been the case for "about two months", and told us this was because these people pulled their curtains down. The service had fitted frosting onto the windows to try to ensure people's privacy whilst waiting for new blinds to be fitted however; this did not fully ensure their privacy. Another person had to have a member of staff with them at all times day and night to maintain their safety, however, other less intrusive methods for protecting the person from risks associated with their condition had not been fully considered. We saw that this person had a support plan in place for behaviours that the service considered to be inappropriate, however staff and the care manager confirmed that this person never had any private time alone to express themselves in this way. This was an intrusion of

the person's right to privacy.

This was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People had a communication plan in place detailing how they communicated and how staff should support them. In one case this was very in-depth with photographs of the signs the person used. However we saw staff did not follow these plans, and did not respond appropriately when people communicated with them. On two occasions a person attempted to communicate with staff, but on both these occasions staff did not follow the guidance in their support plan and take the time to explore what the person was trying to communicate which may have resulted in their needs not being met.

People had care plans in place which detailed their likes and dislikes and how they preferred to be supported. However these likes and dislikes were not always known by staff. For example one person's care plan detailed two types of food the person disliked and we heard two different members of staff offer the person one of the foods they disliked. We spoke with the person and asked them if they liked what had been offered and the person said they did not.

People we spoke with told us they were happy living in the service. We observed one person on a number of occasions singing a certain song and when we looked in their care plan we saw this was their way of communicating that they were happy. Relatives we spoke with felt that their relations had were treated with respect. One relative we spoke with told us that staff were, "Fantastic." The other relative told us, "[Relation] is happy, and eager to go back (after going into the community) and see them. They (staff) are brilliant with [Relation]." The acting deputy manager told us that they felt that caring was the best thing about the service. They told us, "The caring side (of the service) is amazing." We saw examples of caring and compassionate support. One person's care plan described how important physical contact was to them. We saw a member of staff sitting with this person stroking their hand affectionately. The person looked calm and relaxed.

People we spoke with told us they got to make choices, for example about what time they went to bed, what time they got up in the morning and what they ate. One relative we spoke with told us they felt their relation was supported to make choices. Staff told us one person had chosen to have a 'lie in' on the day we visited and we later saw this person who appeared to be happy. We saw on weekly menus that people had a day each week where they chose the food. Records of residents meetings showed that people were asked about what activities they would like. People bedrooms were personalised to their tastes and the acting deputy manager told us they were working with people to help them choose how to decorate communal areas. Support plans contained information to ensure staff knew what choices people were able to make themselves and what they would need support with.

We saw there was one person who was using an advocate and staff had suggested the advocate was asked to speak with all of the people who used the service so they could find out about advocacy services. We spoke to the care manager who informed us that they were planning to discuss this at a forthcoming residents meeting. This meant that people had access to advocacy services when they needed it. Advocates are trained professionals who support, enable and empower people to speak up.

Requires Improvement

Is the service responsive?

Our findings

People were receiving support from staff who did not have information on how to support them appropriately. We found that there was a lack of support planning informing staff about people's support needs. One person was known to have an adverse reaction to changes such as when new staff starting work in the service. This had an impact on the person's anxiety and had in the past resulted in them not eating and losing weight. There was no support plan in place detailing this risk and how staff could support the person and prevent this from happening. Another person had a special diet. Although staff knew about this and we observed the person was given the diet, the lack of support planning meant any new or agency staff would not know about the person's dietary requirements.

People may not receive consistent support because information about their needs and how to support them was not included in their support plans and was often out of date. Five of the six support plans had not been fully updated since 2014. For example, one person needed support with personal care and we saw that their support plan had not been recently updated. The information in the plan was out of date and did not present an accurate picture of the person's current needs. A member of staff told us about how they supported this person with their personal care during the night. We discussed this with the care manager who was unaware of this arrangement and informed us that this was not the way the person should be supported. This lack of up to date information put the person at risk of receiveing inconsistent support with intimate personal care.

One person had suffered a recent trauma that had a significant impact on the person's physical and emotional wellbeing. A member of staff told us how the person sometimes indicated when they wanted support with this issue. There were no details about this in the person's support plan. This put the person at risk of receiving inconsistent support which could have an impact on their emotional wellbeing.

Support plans did not always contain clear detail relating to people's health needs. We were told that one person had a serious health condition and the care manager described the impact this was having on the person. However, the person's support plan did not have any information relating to this health condition to ensure that care and treatment was provided safely. Although staff we spoke with were aware of the person's health condition and we saw support being provided appropriately, there was a risk that the person may not be supported with this health condition in a safe way by new and agency staff.

Care plans lacked any detail about people's goals and aspirations. For example, records showed one person had a number of jobs in the past and had a particular love of a certain type of job. The place where the person had last worked had closed and the person told us they had been disappointed about this. Support for the person to achieve similar work had not been planned for and there was a lack of plans for the person to achieve any other goals they may have. In addition to this some support plans contained in depth information about people's life histories, where as other support plans did not have information in this area. This meant that staff did not always have access to information about people's backgrounds and life histories to inform their support.

People and their relatives were involved in planning and making choices about their care and support. One relative described when their relation had needed input about a certain aspect of their life and they told us they had been fully involved in the discussions around this. Another relative told us, "We are involved and get copies of care plans. [Relation] had a fall and I was notified and things fully explained to me." Records showed that monthly key worker meetings were held to enable people to get involved in planning their care and support. A key worker is a named member of staff who holds responsibilities for overseeing certain people's care and support.

People were supported to follow their hobbies and interests. One person told us they enjoyed playing snooker and that staff supported them to go and play this regularly. They told us about other places they visited such as a social club and the pub. Another person had an interest in aeroplanes and we saw they were regularly supported to visit the airport to look at different planes. On the day we visited they were taken out and were very animated when they returned to the service, telling us about different aeroplanes they had seen. A third person liked to listen to certain music and we saw staff supporting them to listen to this throughout the day of our visit.

We heard staff discussing a party being held at another Voyage service and inviting people from Pelham Lodge to go to the party. One person looked pleased about the party and was smiling and asking questions about the day. Records showed people were supported to engage in a range of activities such as going to a disco, playing snooker, shopping and going out for meals. Staff showed us a room which was being developed into an activity/sensory room and staff told us that people who used the service had chosen the colour of the room and were involved in planning what would go into the room. Staff told us they felt people were given the opportunity to go out into the community. One member of staff told us, "[name] goes out almost every day."

People knew how to raise concerns. One relative told us they would speak with the care manager if they had any concerns and said they felt they would, "deal with issues straightaway." Records showed that people were asked if they had any concerns during meetings held for people who used the service. There was a complaints procedure on display in the service, in a format people would understand, informing people how to raise concerns and what would happen if they did raise concerns. We saw there had been one complaint made in the service in the last year and the record of this showed the complaint had been investigated and acted on appropriately. Staff were aware of how to respond to complaints and their responsibility to act on these.

Requires Improvement

Is the service well-led?

Our findings

Although the registered manager had notified us of some events in the service, they had failed to notify us of a DoLS which was granted for one person earlier in the year. A notification is information about important events which the provider is required to send us by law. We spoke with the manager about this who assured us that they were now aware of their responsibilities to notify us of incidents.

There were systems and processes in place to monitor and improve the quality of the service but these were not always effective in identifying issues. We saw the care manager carried out monthly walk around audits to check areas of the service such as infection control measures and the environment. There had been a recent quarterly service audit which focused on the five key questions used by CQC, is the service safe, effective, caring, responsive and well led. This involved audits which looked at different aspects of the service including the environment, staffing and safety. The care manager's audit had then been checked by the operations manager, who also carried out an audit based on the five key questions, to ensure the care manager was carrying out the audits effectively. Whilst these systems had been effective in identifying some of the issues we found at this inspection; they had not identified others, such as staffing and a lack of applications for DoLS when a person's liberty was being restricted.

Issues identified within the service were not always acted upon in a timely manner to ensure the safety of people using the service. The care manager and the acting deputy manager had identified that a lot of work needed doing on the support plans and record keeping in the service. The acting deputy manager told us, "The paperwork is not great and that is what me and [care manager] are working on." The management team had been in post for a number of months and despite identifying the issues with support plans they had not taken action to ensure that up to date support plans were in place where needed to keep people safe. For example one person who was at of falling from their bed did not have a risk assessment related to this in their support plan. This failure to prioritise development of the support plans put people at risk of harm.

We identified insufficient staffing levels to meet peoples assessed needs and again although the management team were aware of this no action had been taken to put contingency plans in place. In addition to this we saw one person required additional equipment to ensure their safety and dignity, this was known to the care manager however this equipment had not yet been provided.

There was a registered manager in post and they delegated the daily running of the service to a care manager. People we spoke with knew who the care manager was and we saw they responded positively to them. The two relatives we spoke with commented positively on the care manager. One told us, "[Care manager] always rings me if there is an issue." Another relative said, "[Care manager] is very good." The management team had a shared vision to improve the service. They told us how they were working with local community organisations such as the pharmacy and the local day service to build relationships.

Staff we spoke with told us there had been a lot of change at Pelham Lodge over the past few years and said that they felt that things had stabilised since the current management team had been in place. One member

of staff told us, "Since the new manager has been here things have been really good, it has become a pleasurable place to work again." A relative we spoke with knew there had been some issues in the service and that improvements were being made. They told us, "They (staff) are trying to sort things out, they are brilliant at trying to sort things out." Staff told us they felt that the management team were having a positive impact on both the staff and the people living at Pelham Lodge and that people seemed to be happier. One member of staff told us, "People are supported better, its more person centred, we've got time to spend with people and people (who use the service) are calmer."

During the inspection the care manager was open and transparent about the issues they had found when they first started working in the service a few months prior to our inspection. They told us they had made a number of improvements already and had flagged up issues with Voyage and this had been listened to. Voyage had arranged for extra managerial cover to work in Pelham Lodge and make further improvements. They told us that until the service had improved more the provider was not going to admit any new people to fill the vacant three bedrooms.

People were able to give feedback about the service in a number of ways. Although the annual Voyage quality satisfaction survey had not been carried out for over a year, people were able to give feedback about the service in a number of ways including participation in residents meetings and meetings with their key worker. We saw records of monthly meetings where people who lived at Pelham Lodge were supported to discuss things such as finances, safety, food and menu choices and their social lives. People were also supported to think about things they would like to do or try such as going in a caravan at Skegness and a trip to the zoo, and there was evidence that these things had been acted on. We saw that feedback forms had been sent to people who used the service and added to their care plans. Relatives told us they felt they could speak with the care manager at any time. One said, "I go to meetings and if I can't get in, the home will come to me for meetings."

Staff were given the opportunity to have a say about the service during regular staff meetings and staff talked positively about the value of the meetings. Records showed that any actions from previous meetings were followed up to ensure they had been completed. The care manager told us that they had put an 'open door policy' in place where staff or people using the service could talk to the management team at any time and we observed people coming and going from the manager's office throughout the day. The care manager also spent time chatting with people who used the service. Staff we spoke with felt comfortable and confident in raising issues with the management team and felt that if they raised any concerns that they would be taken seriously and it would be acted upon. One member of staff told us "The manager would act on it, [care manager] is very professional."

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 10 HSCA RA Regulations 2014 Dignity and respect Peoples rights to privacy and dignity were not always respected. Peoples diverse needs were not always planned for. Regulation 10 (1) (2) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not always available to meet peoples assessed needs. Regulation 18 (1)