Royal Mencap Society

Royal Mencap Society - Fryers Walk

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

Summary of findings

Overall summary

Royal Mencap Society – Fryers Walk provides services to people living with a learning disability. The regulated activity accommodation for people who require nursing and personal care is provided for up to 16 people. These people lived in a care home which consisted of three bungalows called Foxgloves, Daisy and Poppy. Nursing care is not provided. The regulated activity personal care is also provided to people living in their own flats. These people received a supported living service. All services are provided within walking distance of each other.

The service that is provided has changed since our last inspection on 15 and 24 September 2015. At that time the regulated activity accommodation for people who require nursing and personal care was provided to up to 31 people. The regulated activity personal care was not provided to anyone.

As a result of our findings at our last inspection we asked the provider to make improvements to staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We received an action plan detailing how and when the required improvements would be made by and these actions have been completed.

This unannounced inspection took place on 19 December 2016 and 5 January 2017. There were 15 people receiving care in the care home and seven people receiving care in their own homes.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Although two managers were registered to manage the services, one of these had left in August 2016. The manager of the supported living service registered with the CQC in November 2016. She was also registered to manage another service in South Lincolnshire and divided her time between the two services. Two managers, who were not registered with the CQC were responsible for the care home. One of these managers had responsibility for Foxgloves, and the other for Poppy and Daisy.

Although improvements had been made to the service provided, there was a lack of day to day management oversight. People and their relatives were encouraged to provide feedback on the service. However, this feedback had not always acted on.

Staff were only employed after the provider had carried out comprehensive and satisfactory pre-employment checks. Staff were trained, and well supported, by their managers. There were sufficient staff to meet people's assessed needs. Systems were in place to ensure people's safety was effectively managed. However, these were not always followed. Staff were aware of the procedures for reporting concerns and of how to protect people from harm.

People's medicines were stored safely. However, people did not always receive their medicines as prescribed. People's health and care were effectively met and monitored. People were provided with a balanced diet and staff were aware of people's dietary preferences and needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that there were formal systems in place to assess people's capacity for decision making and applications had been made to the authorising agencies for people who needed these safeguards. Where people did not have the mental capacity to make decisions, they had been supported in the decision making process. People's rights to make decisions about their care were respected in the care home. However, this was not always the case where people received the supported living service.

People received care and support from staff who were caring. Staff in the care home treated people with respect but this was not always the case in the supported living service. Staff knew people well and understood their needs. People's care records provided staff with sufficient guidance to ensure consistent care to each person. People were supported to develop hobbies and interests. However, some people's access to the community was restricted by their funding arrangements.

People had access to information on how to make a complaint and were confident their concerns would be acted on.

We found one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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.

People were not always supported to manage their medicines as prescribed.

There were systems in place to ensure people's safety was managed effectively. However, these were not always followed.

Staff were aware of the actions to take to report their concerns.

Staff were only employed after satisfactory pre-employment checks had been obtained. There were sufficient staff to ensure people's needs were met safely

Is the service effective?

Requires Improvement

The service was not always effective.

In the care home, people's rights to make decisions about their care were respected. However, this was not always the case where people received care from the supported living service
.
Staff knew the people they cared for well and understood, and met, their needs. People received care from staff who were trained and well supported.

Where people did not have the mental capacity to make decisions, they had been supported in the decision making process.

People's health and nutritional needs were effectively met and monitored.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were caring.

People were involved in every day decisions about their care.

Staff in the care home treated people with respect but this was not always the case in the supported living service.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and understood their needs. People's care records provided staff with sufficient guidance to ensure consistent care to each person.

People were supported to develop hobbies and interests.

People had access to information on how to make a complaint and were confident their concerns would be acted on.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although improvements had been made to the service provided, there was a lack of day to day management oversight. Audits were not effective and did not always identify where shortfalls in the service had occurred.

People were encouraged to provide feedback on the service. However, this feedback had not always been acted on.

Royal Mencap Society - Fryers Walk

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 unannounced inspection took place on 19 December 2016 and 5 January 2017. The first day of the inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service. The second day of the inspection was carried out by two inspectors.

Before the inspection we asked for feedback from the commissioners of people's care and Healthwatch Norfolk. We also asked, 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. We used this information to assist with planning the inspection. We also looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about.

During our inspection we spoke with 12 people and one relative. We spoke with 16 staff. These included nine support workers, one senior support worker, one assistant manager, and an administrator. We also spoke with the registered manager for the supported living service and the two managers for the care home. Throughout the inspection we observed how the staff interacted with people who received the service.

We looked at seven people's care records, staff training records and other records relating to the management of the service. These included audits, rotas and policies and procedures .

Following our inspection we received information from one relative, commissioners of care and an audit

officer for Public Health. In addition one of the care home managers sent us further information in relation to staff training and people's healthcare.

Requires Improvement

Is the service safe?

Our findings

There were appropriate systems in place to ensure people received their medicines safely. However, these systems were not always followed. This was particularly the case where people received a supported living service. The registered provider had notified us of medicines errors and told us that actions had been put in place to reduce these. However, records showed that errors continued to occur. On the first day of our inspection one person in the care home was given a medicine that should have been omitted. In the supported living service we found two of one person's medicines were still in their sealed container, but staff had signed that they had administered these. Another person had a medicine that was prescribed to be administered 'when required'. Their record stated there should have had 17 of these tablets left. However, we found there were only 15 in stock. Staff could not explain these discrepancies and the registered manager was not aware of them. The care home manager and registered manager advised they were not aware of these discrepancies.

The registered manager and care home managers confirmed that they carried out a visual check of medicines weekly, but that no formal audits were carried out.

People were satisfied with the way staff supported them to take their prescribed medicines. One person said, "I have my tablets regularly." However, one relative told us, "There's always been a problem with medicines. [Management] get it sorted out, then carers leave and it all starts up again."

Staff in the care homes told us they felt the management of medicines had improved. One staff member told us, I think [medicines management] is good." They went on to tell us that two staff had been identified as "medicines champions". They told us part of this role was to make sure people's medicines were ordered promptly to ensure their prescribed medicines were available.

People's care plans contained clear guidance about their medicines. This included how they preferred to take them and special directions. For example, the circumstances when to administer medicines prescribed to be given 'when required'.

We found that medicines were stored securely. Staff told us, and records showed, that they had received training and that senior staff had assessed their competency to administer medicines. One staff member told us, "I attended a medication workshop, I was then watched preparing and administering medicines whilst working alongside someone else. The manager or assistant manager have to sign staff off as competent before anyone can administer any medication."

Staff in the care home were clear about the procedure to follow if medicines errors were discovered. This included seeking appropriate medical advice and reporting to senior managers. One staff member told us, "If we…make a mistake we are stopped from [administering medicines] and have to go from the beginning [of the training] again."

Where appropriate the provider's disciplinary procedure was used to address unsafe practice. For example,

a manager told us that if a staff member made three medicine errors in a 12 month period, this resulted in the disciplinary or capability procedure being followed. They told us this had significantly reduced the number or medicines errors at the service.

Staff understood the support people needed to keep them safe. For example, a staff member described how they took extra care when using assisting people to move using equipment. They were also aware of the support people needed during periods of distress and behaviour that was challenging to themselves and others. One staff member told us about the importance of "sticking to [people's] routines." They explained various coping strategies they used, such as distractions and increased activities at sensitive times, to reduce the impact of this. Care plans contained clear guidance about how to communicate effectively with each person and how to reduce their anxiety and avoid possible triggers.

Whilst we found staff supported people in the care home to ensure the property was secure. This was not the case for people living in supported living. One staff member told us, "We keep people's front doors on the catch during the day for staff ease of going in and out. Overnight we shut them and use the key pad entry to get the keys." This meant that other people could gain access to people's homes. The registered manager told us that people's front doors should not be "left on the catch". They told us they were aware of the concerns around security and were working to a six week timescale for addressing this.

Managers told us they were in the process of reviewing all people's risk assessments and care plans. We saw that some people had detailed risk assessments showing how to reduce the risk of harm occurring. However, we found that this was not the case for other people. For example, we saw one person sat for long periods of time in a wheelchair. Staff took precautions to stop the person's skin breaking down. These included the use of pressure care cushions, an airflow mattress and assisting the person to regularly reposition. However, the risk of the person's skin breaking down had not been assessed and no care plan was in place addressing this need. Following our inspection a manager told us they had obtained a suitable tool for assessing people's skin integrity and that the community nurse was supporting them to implement this. Staff told us that no-one receiving the service had pressure sores.

In addition, we saw two people had bedrails in place to stop them rolling out of their bed. The use of these had been risk assessed, but this did not include the risk of entrapment in the bedrail. One person had padding over the bedrail to prevent entrapment occurring. However the other bedrail did not have this safety measure in place. The care home manager told us they were not aware of this risk and the provider did not have a policy covering the use of this equipment.

Prior to our inspection a person had fallen from a hoist when staff were assisting them to move. The managers immediately carried out preliminary investigations and reviewed practice to ensure this could not happen again. Investigations into the cause of this incident were on-going at the time of our inspection.

We found that good practice guidance relating to infection prevention and control (IPaC) had not always been followed. An IPaC action plan following an audit carried out by the local authority's IPaC Officer identified numerous areas for improvement. The care home managers told us the action plan was being addressed and we saw some actions had been completed. For example, lime scale had been removed from around taps and plugs.

The care home accommodation was clean and smelled fresh. A relative told us that improvements had been made to the environment over the past year. These included redecoration. They told us the issues of cleanliness that had concerned them had "All improved."

A relative expressed concern that there was not always sufficient staff on duty in all areas of the care home to ensure their relative's needs were fully met. They told us, "There's just too much for staff to do. [People] don't get the quality time with social stimulation."

The manager of Poppy and Daisy told us that people's care needs had increased since staffing levels were initially agreed with commissioners. They said they had requested some people's care packages were reviewed. They showed us they had completed detailed analysis of people's care and support needs and the number of staff needed to meet these. Whilst the current staffing levels were safe, this analysis showed the staffing levels did not enable people to lead fulfilling lives. The manager told us they were in negotiation with commissioners to increase the staff levels for those people whose needs had increased.

Staff told us that staffing levels had recently improved. One staff member said, "We weren't always achieving [our agreed staffing levels] but we have in the last three months or so." They told us that staff absence was covered by permanent staff working additional shifts or by bank or agency staff. The staff member said, "We do get the same agency staff now so they know [the people]." We saw that staff members were always available when people needed care or support. We therefore found there were sufficient staff to safely meet people's needs.

The provider had a robust system in place that ensured satisfactory checks were obtained before prospective staff started working with people. This ensured staff were only employed once the provider was satisfied they were suitable to work with people who used the service. These checks included written references, proof of recent photographic identity as well as their employment history and a criminal records check.

People receiving the service said they felt safe. One person told us, "Yes we're safe here, it's alright." Another person said, "No one has shouted at me here."

Staff told us they had received training to safeguard people from harm or poor care. They showed they had understood and had knowledge of how to recognise, report and escalate any concerns to protect people from harm. One member of staff said, "I would feel confident to whistle blow and would know what to do and who to contact." Another staff member showed us where they could find emergency contact numbers. All staff told us they felt confident that their manager's would act on any concerns they raised.

Staff were aware of the provider's reporting procedures in relation to accidents and incidents. Accidents and incidents were recorded and acted upon. For example where any untoward event had occurred, measures had been put in place to monitor people more frequently. We saw that the potential for future recurrences had been minimised.

Staff considered ways of planning for emergencies. Each person had an individual evacuation plan within their care plans. This helped to ensure that appropriate support would be given in the event of an emergency, such as a fire at the service.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 15 and 24 September 2015 we found that mental capacity to make decisions was not being appropriately assessed. In addition, staff did not have the appropriate training to fully understand the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We received an action plan detailing how and when the required improvements would be made by and these actions have been completed.

This was a beach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 under the regulated activity accommodation for people who require nursing and personal care.

Following our inspection in September 2015 the registered manager told us improvements would be made by 29 February 2016.

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). For people in the supported living service, an external agency would make the DoL application to the Court o Protection.

During this inspection on 19 December 2016 and 5 January 2017 we found the service was working within the principles of the MCA in the care home. The managers had made applications for DoLS where appropriate. For example, where people had been assessed as requiring staff support to access the community and where people were not free to leave the care home alone. This meant people were only deprived of their liberty lawfully.

People were supported by staff who had a good knowledge and understanding of the MCA. One staff member told us, "Yes I've done MCA training. It's about the person having their own life and making their own decisions. Where they can't make those decisions we have to make a best interests decision." In the care home, both staff and managers we spoke with had a good level of knowledge about their duties under the MCA and how to support people with decision making. A staff member told us about a person whose heath benefited from observing a particular diet. They told us, "We try and persuade [the person] to have a better alternative. Sometimes [they] will, other times [they] won't. [The person] has capacity so it's [their] choice."

Where people living at the care home had been assessed as not having the mental capacity to make specific decisions, we saw that decisions were made in their best interest. Records showed that the views of appropriate people had been taken into consideration. This included people who knew the person well or

the person's legal representative. This showed that consideration had been taken to ensure the service was, in the main, provided in people's best interest and in the least restrictive manner.

However, in the supported living service we found this learning had not been embedded and people's rights were not always upheld. We found that in a flat two people shared, staff had locked squash bottles in a cupboard that only they had access too. A staff member told us that this was because some staff believed the squash had a negative impact on a person's health. There was nothing in the persons care plan to state their fluid intake should be monitored or reduced or that the squash should be locked away. This also negatively impacted on the other person living in the flat who told us they had to wait for staff to unlock the drink. The registered manager confirmed the drink should not be locked away.

People were protected from the use of avoidable restraint. People who sometimes communicated through their behaviour were supported by staff who recognised how to support the person and how to respond in a positive way. There were care plans in place informing staff of what may trigger the behaviour and detailing how staff should respond. Staff were given training on how to respond to behaviour using least restrictive methods and the techniques which worked for each person were clearly recording in people's care plans. We found that staff we spoke with had a good knowledge of these plans and applied this knowledge when supporting people throughout our visit.

In the PIR the registered manager told us, "All new staff complete a 12 week care certificate induction which involves formal class room training, workbooks, observations and shadowing. A 12 week Care Certificate Mandatory training Induction for all new staff with built in shadowing and service orientation." Staff confirmed this was the case. One staff member told us, "My induction was good, really informative, lots to take on board. It was very thorough." Another said, "I shadowed another member of staff to start with, which gave me time to settle in." The care certificate training included a set of standards that social care and health workers must apply in their daily working life. It is the minimum standards that should be covered as part of their induction training as a new care worker.

Staff told us, and records showed, they were trained in the subjects deemed mandatory by the provider such as moving and handling, first aid, and safeguarding people from harm. One staff member told us, "I have undertaken a variety of workshops and training courses which have helped me to do my job." Records showed that following training, staff members' competency was tested through written tests and or senior staff observing their practice. One staff member told us this training enabled them to "feel confident in my job."

Staff had also had the opportunity to receive training in other areas relevant to the needs of the people they were supporting. For example, one person had recently been diagnosed as living with dementia. A manager told us that in addition to sharing their own knowledge of dementia, staff training had been booked for February 2017.

Staff members told us they felt well supported by their managers. This included regular formal supervision meetings where practice and development issues were discussed and addressed. One member of staff told us, "I have had regular meetings with my line manager. They ask me about my home/work life balance and how I am, it's very supportive." Another staff member said, "I have a 'Shape your Future' meeting [work appraisal] every year. I also have supervisions often. They ask me if I am happy at work. They are useful."

People were encouraged to make choices about the food they ate. People told us staff supported them to have enough to eat and drink. We heard one person ask for a drink and this was readily addressed by the staff supporting them. Across the service, people were involved in the decisions about the food and drink

they consumed. Staff told us they encouraged people to eat healthily and we saw information was available to support people to do this. One staff member told us, "People can choose to eat all the wrong foods; it's not right but now we're supported living staff [and] can't control it anymore. We advise healthy diets but [people] don't have to take our advice." Staff supported people to eat food that was in line with their cultural beliefs and preferences.

Staff supported people to shop for their own food and devised weekly menus. We heard staff discuss with people what they would like to eat at meal times, offering advice and choices in a way people could understand.

People were supported to be as independent as possible when eating and drinking. For example, one person's care plan stated that they had their own spoon which the person was able to use to feed themselves. We saw staff ensured this was made available for the person.

Staff were aware of people's individual dietary and related care needs and catered for these. For example, we were asked not to speak with one person while they were eating as this may cause the person to lose interest in their food. Staff were aware that another person had guidance in place from healthcare professionals about the consistency of food and position the person should sit in when eating and drinking to help prevent aspiration. Some people were assessed as needing their food and fluid intake monitored. Although staff told us this information was recorded contemporaneously, we saw this was not always the case. In addition, we saw some entries did not detail the amount the person had consumed.

People were supported to manage and maintain their health and had access to health care professionals. These included speech and language therapists, dieticians, physiotherapists, occupational therapists and GPs. Staff had good knowledge of people's healthcare needs. They described people's diagnosed health conditions and symptoms and any regimes in place to manage these. For example, regular bed rest and a soft diet which was also high in calories to reduce the risk of pressure sores.

Staff monitored people's health. A relative told us that their family member had a diagnosed health condition. They told us that the manager had identified that their family member's care plan may no longer be meeting their needs in relation to this and required review. The manager had contacted the relevant health professional who was in the process of doing this.

Good

Is the service caring?

Our findings

People told us they liked the staff who supported them. Relatives described staff as, "Nice" and, "Caring". One relative said, "[My family member] engages in real relationships with the staff and jokes with them … [My family member] always appears very comfortable with the staff members. Of course there are always the few one doesn't connect with so well, but this is normal in a community situation."

During our inspection we saw staff interacted well with people. They addressed them by their preferred name and spoke in a calm and reassuring way. They engaged in natural conversation about day to day support and interests. Staff demonstrated to us that they knew people well. One staff member told us, "You have to understand people's moods. You have to think before you promise things or they won't have the trust in you. It's basic respect. It all goes hand in hand."

Staff told us they would be happy for a family member to receive care from this service. One staff member said this was because, "I know that everyone works to [people's] best interests." Another staff member said the staff team were "really good, really caring. They go the extra mile. [They're] not just doing a job. They are genuinely interested [in the people]."

Throughout our inspection staff maintained a caring attitude towards people. This included ensuring people were comfortable. A staff member saw a person falling asleep at the table after a meal. They explained to the person they may be more comfortable in the lounge and assisted the person to move to an armchair. They asked the person if they would like a fleecy blanket to cover them and did they want television on. They then consulted the person about the programme and the volume of the television. Staff demonstrated they understood the different methods people used to communicate and responded to their requests.

The registered manager had recognised that the staff providing the supported living service were not always working in the way which promoted peoples independence. The service manager had brought two experienced staff from another of the provider's service to work with staff two days a week to assist the team in developing this. One of these staff told us, "I'm here a couple of times a week helping staff with supported living. We found some staff here were doing too much for people and others not enough. We're teaching the staff how to support people." Some staff had taken this on board. One staff member told us, "People have a voice now; they can say what they want." Another said, "People are now independent, they sometimes do their cleaning but they can also say no." However, one person told us, "I don't like one member of staff who is bossy and tells us to do our cooking."

Staff in the care home talked passionately about the people they supported and how they promoted people's independence. Staff supported people with everyday activities of daily living. For example, opening their front door to visitors and cooking meals. One staff member told us, "I really enjoy my job. We encourage independence and help people to get out and socialise."

In the care home staff treated people with respect, knocking on the front door and checking with people before they provided care. We observed staff speaking respectfully to people and involving them in

conversations. However, in the supported living service this was not always the case. During our inspection we saw staff walking in and out of a person's flat to speak with staff on duty there. A staff member brought a person to someone else's flat expecting to leave the person there while they went out with other people. The staff member said, "[The person] always waits in here whilst we are out." Another staff member challenged them on the appropriateness of this and the lack of consultation with the people who lived in the flat.

Staff members told us they involved people in their care by talking with them and asking them how they wanted their care provided. We observed this taking place during our inspection. Care plans provided staff with guidance about people's communication methods and personal preferences. Relatives told us staff consulted them about their family member's care. However, one staff member told us, "I don't know how people we support are involved in their care plans, I haven' done that." In the supported living service, records did not show that people and or their relatives were involved in reviewing their care plans. People told us they did not know how their care plans were reviewed.

Good

Is the service responsive?

Our findings

People and relatives felt that staff understood and responded to people's needs. One relative told us, "I feel that the level of care is very good." Another relative told us that the care their family member received had improved considerably over the last year. They told us about their previous concerns and said "But all that is perfect now." They described how staff effectively met their family member's personal hygiene needs. They said, "I've told [the manager] they've made a remarkable turnaround."

People's individual needs had been assessed. This information included people's life history and their personal preferences. Each person had a range of person centred care plans in place that clearly guided staff in how to support them in the way they preferred. These included managing personal care, health conditions, medicines and communication needs. It also included what was important to the person when staff were delivering care. This information helped to ensure that the care effectively and consistently met people's needs.

Staff supported people to maintain relationships with family and friends. One person told us, "[Staff] took me to visit my [relative]. It was a long drive and we stopped for a burger on the way home." A relative told us staff supported their family member to regularly speak with them on the telephone.

People were supported to access a range of activities and develop interests. These included attendance at education centres and or individual time with staff. People told us they attended music clubs, exercise classes and accessed community resources. For example, pubs and shops which were close by. One person told us, "I go to befrienders. I like to go to the pub. I like to go shopping to buy clothes and things for me." In one bungalow people showed us that staff were supporting them to care for their pets. A staff member said, "People get to do things for themselves, they have an opinion." One person asked staff if they could go out and purchase a vacuum cleaner. Staff agreed and planned to support the person with this later in the day.

Staff also supported people to take holidays and trips further afield. For example, one person told us how much they had enjoyed their trip to a "winter wonderland" in London. The person's face lit up when staff reminded them about what they had seen and experienced, including ice-skating.

A relative told us, "[Staff] told me all the things [my family member] has been doing recently. They are all the things [my family member] loves to do, so really I am quite satisfied. They do seem to make an effort to help [my family member] live a fulfilled life." Another relative told us their family attended two clubs each week which they enjoyed. However, they said their family member's needs had changed and staff were no longer able to support the person to go to church regularly. They told us, "[My family member] likes church. [My family member] went [to church] all the way through his life." The manager told us that they had requested this person's commissioner reassess the level of care they required.

People and their relatives said that staff listened to them and that they knew who to speak to if they had any concerns. Everyone we spoke with was confident the registered manager or another member of staff would listen to them and address any issues they raised.

One relative told us about concern they had raised with the manager. They said they had never been "shunned or pushed to one side" when they raised concerns with the manager. They told us the manager had addressed their concerns and assured them it would not happen again. They said they had raised a minor concern the previous week. They commented, "I've taken it to [the manager who] said [they're] on to it. This week [staff] are doing that. [The manager has] got that one sorted out."

Staff had a good working understanding of how to refer complaints to senior managers for them to address. Where a complaint had been received we saw that this had been followed up with a detailed response covering each of the complainants concerns.

Requires Improvement

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Although two managers were registered to manage the services, one of these had left in August 2016. The manager of the supported living service registered with the CQC in November 2016. She was also registered to manage another service in South Lincolnshire and divided her time between the two services. Two managers, who were not registered with the CQC were responsible for the care home. One of these managers had responsibility for Foxgloves, and the other for Poppy and Daisy.

There was a lack of management oversight across the service, but particularly in the supported living service. We found that neither the registered manager nor assistant manager were aware that there was a medicines error on 1 January 2017 and that 111 were contacted for advice. They were also unaware that staff locked squash away from two people. The registered manager for the supported living service confirmed these people should have had unrestricted access to this. Another person had been admitted to hospital from the care home, but the relevant manager was unaware the person's care notes had not been completed the night before their admission.

A survey had been used to gather people's views. This was in an accessible easy read format. However, these did not include the date of when they were undertaken so it was not clear when the feedback was obtained. This meant it was not clear whether subsequent actions have been completed in a timely manner or at all.

We noted on one survey that the person reported personal jewellery and other items had gone missing during a house move. There was no action recorded on the form and the registered manager had no record of whether action was taken or not. They told us there had been a "different management team then so don't know."

We found medicines audits were not effective. The care home managers and registered managers told us that they, or other senior staff, visually checked people's medicines and associated records weekly. However, they had failed to identify medicines discrepancies that we identified. Despite the number of medicines errors in the past, no formal medicines audit had been implemented.

The registered manager and care home managers used an electronic audit tool to monitor care plans and systems such as risk assessments, healthcare access and finances. A traffic light system was in place to identify and highlight when actions were due. As a result a continuous improvement plan was drawn up and monitored by the care home managers and registered manager.

The registered manager for the supported living service had an understanding of their role and responsibilities. They were aware that they were legally obliged to notify the CQC of incidents that occurred

while a service was being provided. Records we looked at showed that although notifications had been submitted to the CQC in a timely manner, this had not consistently been the case.

Staff had differing views about team morale. One staff member told us, "Morale is pretty good. Some staff that have seen all the changes may be somewhat disgruntled as it is all changing." However, another said, "It's not a good team at the moment; there are so many new starters who need time to settle in. We used to work as a team but it's the new staff not helping this." The registered manager recognised that staff needed support to understand the concepts of supported living. They had responded by bringing in staff from an established supported living service to provide guidance and support to the existing staff teams. She told us that she recognised that more structure was needed and she was planning that the assistant manager would also be working alongside staff more.

This is a breach of Regulation 17(1) and (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received very positive comments about the registered manager of the supported living service and the managers of the care home. A relative told us they had seen "vast improvements" in the service their family member received in the care home. People who used the service knew the management team and clearly felt comfortable with them.

Staff and relatives told us significant improvement had been made to the environment of care home and the care people received. They told us the cleanliness of the service had improved, rooms had been decorated and the gardens made safe and a pleasant place to spend time. One relative told us, "[The manager] and [assistant manager] have made a vast improvement here." They went on to tell us that they felt their family member received an improved standard of care and was much happier as a result.

Commissioners also said they had seen an improvement in the service people received. They told us that the managers took on board their comments and were keen to improve the quality of the service. The registered manager and managers showed us improvement plans they had devised to meet the current shortfalls in the service.

Staff were also complementary about the managers. They told us "Both [manager] and [assistant manager] are very approachable. They try to sort out any problems, sometimes they can't, but they do try." Another staff member said, "[My manager] is an amazing manager. You can always go to [them]. I hope [they] stay." Staff said they felt well supported. Although the registered manager and one of the care home managers were not based at the service all the time, staff told us they were always able to contact them or the on call service by telephone in an emergency.

Staff were knowledgeable about people's care needs. They said in addition to people's care plans they had a handover at the start of every shift when important information about people's changing care needs was shared with them.

Relatives told us they felt comfortable raising issues with the managers. They said the care home managers listened and acted on their comments. One relative said, "I was really pleased that [the manager] took my comments seriously."

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 Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of management oversight across the service. Systems did not effectively identify shortfalls in the service. Feedback from people was not always acted on. Regulation 17(1) and (2) (a) (b) (e) (f)