Isle of Wight Council

The Gouldings

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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The Gouldings is a local authority run care home for short term respite and reablement support. Reablement is a way of helping a person to remain independent by giving them the opportunity to re-learn or regain some skills for daily living that may have been lost as a result of illness, accident or disability. The home provides accommodation for up to 35 older people, including people living with dementia. At the time of our inspection there were 25 people living at the home.

The Gouldings also provided a reablement service for a limited period in a person's own home that includes personal care; help with activities of daily living, and practical tasks around the home.

The last inspection of the home took place on 4 April 2013 and no concerns were identified. However, an inspection of the community reablement aspect of the service between the 17 and 20 September 2013 identified

Summary of findings

breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took enforcement action and required the provider to make improvements.

This inspection, which was unannounced and carried out on 31 March 2015, 2 and 7 April 2015, look at both aspects of the services provided by The Gouldings. During the inspection we found the provider had completed all the actions they told us they would take in respect of the community reablement aspect of the service.

At the time of inspection the manager was not registered because the previous registered manager had recently left. The new manager had started the process to become the registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered provider's, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run.

People told us they felt safe. However, not all risks to people using home had been identified, which could impact on their health and wellbeing. Risks relating to people using the community reablement service had been identified and were effectively managed.

There was not an effective system in place for the storage of medicines at the home, leading to inconsistencies in the records relating to the quantity of medicines being stored. In addition there was no system in place to ensure that medicines were stored at the correct temperature.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. Although staff were aware of the principles of the MCA, they did not have access to sufficient information to enable them to understand the ability of a person living with dementia to make specific decisions for themselves. In addition, the home did not have decoration or signage that would aid people living with dementia find their way around and be as independent as possible. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

The home did not have decoration or signage that would aid people living with dementia find their way around and be as independent as possible. We have recommended that the provider seek advice and guidance on how to make the environment used by people living with dementia more 'dementia friendly'.

People's care plans were generic in style and although detailed they were not person centred and did not focus on people's individual health needs or wellbeing. We have recommended that the provider seek advice and guidance on person centred care planning, including activity plans.

Pre-assessments did not always contain sufficient detail to ensure staff at the home were able to meet people's needs prior to their arrival. However, once they arrived people were involved in the assessment and planning their care.

Accidents and incidents were recorded but did not always contain sufficient information to allow the manager to understand what had occurred and take remedial action to prevent reoccurrence.

The audits undertaken to monitor the quality of the service provided were not sufficiently robust to ensure the service continually improved.

Staff were aware of and responsive to people's needs and preferences as to how they wanted to be cared for. Staff were caring and developed positive relationships with people. They encouraged them to maintain their independence and supported the decisions and choices people made. They also checked that people consented before supporting them.

People were complimentary about the quality of the food and were supported to have enough to eat and drink.

People were supported to see health professionals when needed.

Recruitment procedures were safe and appropriate checks were completed before staff were employed. There were enough staff across the whole of the service to meet people's needs and staff were supported to carry out their duties to deliver care and treatment safely.

Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and

Summary of findings

explain the action they would take if they identified any concerns. However, the manager did not always recognise the potential safeguarding risks from external influences.

People and visiting relatives told us they felt the service was well-led. The provider had a clear vision for the home and staff understood their role in delivering that vision and were encouraged to become involved in developing the service.

The provider sought feedback from people using the service and their relatives in respect of the quality of care provided and had arrangements in place to deal with any concerns or complaints.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not always safe.

People's health risks were not always identified and managed effectively.

People's medicines were not always stored effectively leading to inconsistences with records and the inability to check medicines were kept at the correct temperature.

Staff were aware of their responsibilities to safeguard people, however they did not always identify potential safeguarding risks.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Requires improvement 

The service was not always effective.

Staff supporting people living with dementia did not have sufficient information to enable them to understand the ability of a person to make specific decisions for themselves.

People were complimentary about the food and were supported to have enough to eat and drink.

People had access to heath professionals and other specialists if they needed them.

Staff received an appropriate induction and on going training to enable them to meet the needs of people using the service.

Is the service caring?

Good 

The service was caring.

People and their relatives were involved in planning their care. Staff used care plans to ensure they were aware of people's needs.

Staff developed caring and positive relationships with people using the service.

People were treated with dignity and respect.

Is the service responsive?

Requires improvement 

The service was not always responsive.

Pre-assessments did not always contain sufficient information to enable the service to assess people's needs prior to arrival.

Care plans and activities were not always person centred or focussed on individual needs.

Summary of findings

Staff were responsive to people's needs and encouraged them to maintain their independence.

The provider sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

The service was not always well-led.

The audit process used by the manager did not always identify issues and drive improvement.

The providers' values were clear and understood by staff and the manager adopted an open and inclusive style of leadership

Staff had the opportunity to become involved in developing the service.

The manager understood the responsibilities of their role and the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service.

Requires improvement

The Gouldings

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 checked 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.

The inspection was unannounced and was carried out on 31 March, 2 April and 7 April 2015. 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. The expert supporting this inspection had experience for caring for an older family member both at home and in a residential environment.

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. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We met with the 11 people staying at the home and nine visitors. We also spoke with 16 people using the community based reablement service by telephone. We observed care and support being delivered in communal areas of the home. We spoke with seven members of the care staff, the cleaner, an administrator, the duty manager for the community reablement team, the manager and the group manager for the provider. We also spoke with a community nurse, an occupational therapist and two local authority care managers, all of whom gave their permission to be quoted in this report.

We looked at care plans and associated records for nine people using the service, staff duty rota records, two staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Requires improvement

Is the service safe?

Our findings

People across the whole of the service told us they felt safe. One person said they felt happy and safe, "I had a fall at home but I feel very safe here and can relax as I am being looked after". A visiting friend said "I have no concerns at all, it is absolutely wonderful here". A relative for a person staying for a period of respite told us, "three of us look after him when he's at home but we can relax as we know he's safe when he's here".

However, during our inspection we found that people were at risk of receiving unsafe care because the provider and manager did not have an in depth understanding of risk management or effective systems in place to mitigate risks and ensure the welfare and safety of people at the home.

One of the home's rooms was being used by a person who was being supported by staff but not receiving personal care. The manager was unable to disclose to us with any detailed information in respect of this person, their background or the risk they may present to people using the service. They did confirm that no background checks or risk assessment had been completed. People and staff were put at risk as a result of the decision to allow this person to live at the home without appropriate checks and associated risk assessments. Following our discussion with the manager, risk assessments in respect of this person had been put in place by the second day of our inspection. However, these were focussed at the individual and did not reflect the risks they may pose to other people using the service.

There was a lack of understanding that risks assessments should be person centred and reviewed in line with changing circumstances. A number of people using the home were self-medicating a broad range of medicines. Although there was a risk assessment completed for people who chose to self-medicate, these were generic and did not reflect people's individual abilities, needs and the nature of the different medicines they were taking. For people who had been at the home for more than a month, or whose medicines had changed, there was no record of any reviews of the risks relating to their ability to self-medicate.

There was a lack of consistency of record keeping in respect of risk identification and as a consequence staff may not always be aware of risks relating to people staying at the home. For example, one person's care records showed there was an infection risk relating to that person. However, in a different part of their records, completed on the same day, there was contradictory evidence stating they did not present an infection risk.

The lack of an effective system in place to identify and mitigate risks relating to the health and safety of people using the service was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks relating to people using the community reablement part of the service were identified and managed. The risk assessments for people using this aspect of the service were current and reflected people's needs and abilities.

At a previous inspection of the community reablement aspect of the service we identified that the provider had failed to take reasonable steps to identify the possibility of abuse and prevent it before it occurred. During this inspection we found that staff and the manager, across both aspects of the service, had the knowledge necessary to enable them to respond appropriately to concerns about people. They had received safeguarding training and knew what they would do if concerns were raised or observed in line with their policy. Staff had also completed or were in the process of completing a vocational qualification in care, which contains a section relating to safeguarding. Where safeguarding concerns were identified they were investigated internally and reported to the appropriate authority. However, the manager did not recognise the safeguarding risks related to people living at the home without the appropriate checks being completed.

Medicines which required storing within a specific temperature range were not always managed effectively. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. However, there were no arrangements in place to check the temperature of the fridge to ensure it was working correctly and the medicine was stored at the appropriate temperature. We raised this with the duty manager as an area for improvement.

Requires improvement

Is the service safe?

The provider had a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions. However, we did find one instance where the record relating to one person's medicine did not correspond with the amount of medicine held in stock. We raised this with the duty manager and they were unable to account for the discrepancy. As a consequence the provider could not be assured that the person had received their medicine as prescribed.

The provider had an up to date medicine policy, which provided detailed guidance for staff. Only the duty managers, who had received the appropriate training and had their competency assessed were able to administer medicines to people staying at the home. People's medicine administration records (MAR) had been completed correctly and were audited on a regular basis. The MAR charts also included guidance on when 'as required' (PRN) medicine should be administered and the action to be taken if a person refused to take their medicine. There was a process in place for the ordering of repeat prescriptions and disposal of unwanted medicines.

Staff supporting people in the community had also received medicine administration training and were correctly completing the MAR charts for the people they supported.

Accidents and incidents were recorded but the records did not always contain sufficient information to allow the manager to understand what had occurred and put in place remedial action to prevent reoccurrence. For example, one accident record showed a person had sustained an injury and required medical attention. However, there was no information as to how the injury had occurred. Accidents were reviewed by the duty manager however the lack of information in respect of this accident had not been identified and acted on. We raised this with the manager as an area for improvement.

At a previous inspection of the community reablement aspect of the service we identified that the provider had failed to ensure there were sufficient staff available to meet people's needs. During this inspection we found there were enough staff across the whole of the service to meet people's needs. The staffing level in the home provided opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. The care staff in the home were supported by housekeeping, maintenance, kitchen staff and a day care assistant, which meant they were not distracted from their day to day care duties. One person told us "If I use my buzzer, staff answer it and if I need them, they come very quickly". A relative said, "staff here have time to talk to you and they are helpful". A health professional told us "there always seems to be staff around. They seem to know where people are when I ask them". A care manager said "there is always enough staff around when I visit". The allocation of staff working in the community was based on each person's needs.

There was a duty roster system, which detailed the planned cover for the home and the community reablement team. Short term absences were managed through the use of overtime or bank staff employed by the provider. The manager was also available to provide support when appropriate. Therefore, there were management structures in place to ensure staffing levels were maintained.

The provider had a safe and effective recruitment process in place to help ensure that staff who were recruited were suitable to work with the people they supported. All of the appropriate checks, including Disclosure and Barring Service (DBS) checks were completed on all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

There were arrangements in place to deal with foreseeable emergencies. There was also a fire safety plan for the home. Staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm went off.

Requires improvement

Is the service effective?

Our findings

People across the whole of the service told us they felt that the service was effective and that staff understood their needs and had the skills to meet them. One person said "the staff are qualified to meet my needs, they are very good". The visitors told us they felt staff were knowledgeable about the care they provided and said their family members needs were met to a good standard. The health professionals and the care managers told us staff understood people's needs and had the skills to meet them.

The Mental Capacity Act 2005 (MCA) provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant.

People told us that staff asked them for their consent when they were supporting them. The manager and staff understood their responsibilities in relation to the MCA. They were able to explain the principle of capacity and how it applied to people using the service. However, although people's care records included a section on emotional wellbeing which identified any cognitive concerns, there was no information in the assessments of those people identified as living with dementia to assist staff in understanding and supporting the person's ability to make specific decisions for themselves. We raised this with the manager who agreed it was an area for improvement.

The home did not have decoration or signage that would aid people living with dementia to find their way around or to be as independent as possible. The home was painted in a single bland colour and there were no dementia friendly signs to indicate toilets or to identify people's rooms. **We recommend that the provider seek advice and guidance on how to make environments used by people living with dementia more 'dementia friendly'.**

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, we found that the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

At a previous inspection of the community reablement aspect of the service we identified that the provider had failed to ensure that care staff were appropriately supported in relation to their responsibilities. During this inspection we found that there were arrangements in place to ensure staff across both aspects of the service received an effective induction into their role. Each member of staff had undertaken an induction programme based on "Skills for Care Common Induction Standards" (CIS). CIS are the standards employees working in adult social care should meet before they can safely work unsupervised. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, fire safety, infection control, health & safety and control of substances hazardous to health (COSHH) training. Staff had access to other training focussed on the specific needs of people using the service. For example, Glucose blood monitoring, Stoma Training and Palliative Care. Staff were also supported to achieve a vocational qualification in care. Training opportunities were displayed on the staff board. One member of staff said "This is the best place I have worked for training. They put the course on the board and you can choose what you want to do". Staff were able to demonstrate an understanding of the training they had received and how to apply it. People told us that staff had the skills to meet their needs

Staff received regular supervisions and an annual appraisal. Supervisions provide an opportunity to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Staff said they felt supported, and the manager had an open door policy and they could raise any concerns straight away.

People told us that staff encouraged them to make decisions and supported their choices. One person told us "it is your choice whether you have your bedroom door open or closed". Visiting health professionals and care managers told us they did not have any concerns over how staff supported people to make decisions. We observed that staff promoted decision making and respected

Is the service effective?

people's choices. For example, one person asked if they could sit on his own while eating lunch. Staff then arranged a table for them to eat at where they were on their own and away from other people eating their lunch.

People were supported to have enough to eat and drink. Meals were appropriately spaced and flexible to meet people's needs. People were complimentary about the food. One person told us "there are lovely lunches here and nice people". They added there were plenty of drinks available. Another person said "I like the food; I eat anything because I am here to build myself up". A third person said they were vegetarian and the kitchen always provided a vegetarian option for them.

Kitchen records showed that people's likes and dislikes, allergies and preferences were recorded. There was a menu board on display in the dining area and staff checked with people at breakfast what they wanted to eat for the rest of the day. People were then asked again at lunch what they wanted to eat for their tea. They were also offered a choice of medium or small portion. Staff were patient when explaining the choices. One person said to a member of staff, "I can't remember what I ordered". The member of staff said it did not matter and then went through the menu choices with them.

Healthcare professionals such as GPs, district nurses, chiropodists and occupational therapists were involved in people's care where necessary. Records were kept of their visits as well as any instructions they had given regarding people's care. One person said "one of the staff spotted I had a problem while they were washing me, they called a nurse, then a doctor, who referred me to a consultant who told me I had cancer. I wouldn't have known had it not been for them". One visiting health professional told us "staff are very good at carrying out our instructions" and added "we know they have done it because you can see the improvements".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People across the whole service and visitors to the home told us they did not have any concerns over the level of care provided or how it was delivered. One person said "the carers and I chatter all the time and we laugh. They are very kind". Another person told us it was an “excellent service, they are very kind and considerate, couldn't do more for me". A third person said “The young carers are very good they really care for old people”.

We observed care in the communal areas of the service and saw staff had a good knowledge of people and had developed strong friendly relationships with them. Staff interacted with people in a positive and supportive way. For example, one of the cleaning staff raise a concern with a member of care staff that they had seen a person sat in their room who was crying. The member of care staff immediately went to check on the person. They spoke with the person in a kind and supportive way, identified what was causing their anxiety and stayed with them until they felt comfortable. On another occasion, a member of staff gently woke a person up at lunch time. They gave them time to wake up properly before assisting them to their seat, advising them to, “gather [their] thoughts for lunch”.

This experience was the same for people being supported by the community reablement team. Comments included “they are brilliant”, “they have all been friendly” and "the girls are very nice they do everything I ask them to do".

Staff used the information contained in people’s care plans to ensure they were aware of people’s needs and preferences. Staff understood the importance of respecting people’s choice, privacy and dignity. They spoke to us about how they cared for people and we observed that personal care was provided in a discreet and private way. Staff knocked on people’s doors and waited before entering. The movement of the people at the home was unrestricted and they were able to choose where they spent their time. We spoke to some people who chose to spend their time in their own rooms. They said the staff respected this and offered them opportunities to join others if they wished.

The health professionals and the local authority care managers we spoke with told us they did not have any concerns with how people were treated. A visiting health professional said “I have never had any problems with any of the staff. They are respectful, polite and caring”. A care manager told us “I have no concerns with regard to respect and dignity. I would be happy for my mum or dad to be placed here”.

People and their relatives had been involved in the planning of their care. The care plans covered a number of areas of a person’s support needs, the preferred or desired outcomes and their personal preferences. For example, the gender of the care staff who support them with personal care, the frequency of night checks and whether people wanted their door left open or closed. One person said “when I came in they went through everything with me and checked what care I wanted. They asked me whether I wanted a man or woman to help me and what time I wanted waking up”. Another person told us their care plan was in a folder in their room, and they said they were aware of the contents. The care managers told us they were there to support people as part of their care review.

People being supported by the community reablement team told us there was a copy of their care file kept at their home and staff looked at these before providing care.

Requires improvement

Is the service responsive?

Our findings

People across the whole of the service told us staff were responsive to their needs. One person said, “I am very happy here, they have helped me understand I cannot cope at home. I would want to stay here if I could”. Another person said “Staff are here to help if you need them. They check on me through the night to see if I’m okay”. Visitors told us that people received good care and personalised support based upon their individual needs. A relative said “It is absolutely wonderful here. It is like a hotel. Whatever they need they get for them”.

Staff across the whole service were aware of and responsive to people’s needs. One family member told us their relative regularly stayed at the home for respite. They said, “This week he came for a day visit but was unwell. Staff understand his needs, they called a GP straight away and arranged for him to stay here for a few days. Their care has been wonderful”. One person using the community reablement service told us, “The girls are very nice they do everything I ask them to do".

At a previous inspection of the community reablement aspect of the service we identified that the provider had failed to ensure that people were assessed effectively and received the care and treatment which met their needs. During this inspection we found that the care records within the reablement aspect of the service were person centred and contained sufficient information to assist the reablement staff in understanding how to meet a person’s individual needs. However, the care records within the home did not always contain sufficient information to support new members of staff who may be unaware of people’s individual needs. Care plans were detailed, renewed for each period of respite and reviewed regularly. They included areas such as, personal care needs, spiritual and psychological wellbeing, and skin integrity. Although care plans were detailed, they were generic in style and were not always sufficiently person centred to allow staff to understand people’s individual needs. For example, one person’s care plan recorded they were diabetic; however, there was no information as to what foods they should be avoiding. In also showed they needed support from one member of staff for showering but did not have any details as to what assistance was required and how much they could do for themselves. Another person told us that health professionals were treating them for an open sore on their abdomen. This information was not detailed in their care plan.

The home had a structured approach to activities, which included activities lead by an activities coordinator, such as arts and crafts, reminiscence quizzes or bingo. There was also a programme of visiting entertainers and musicians. These were held in the lounge area of the home and were also attended by day care visitors. These provided an opportunity for some people to socialise with other people from outside of the home environment. Pictures created by people during the arts and craft session were displayed around the home. In addition, there were books and jigsaws available in quiet areas of the home. People also had access to the internet via a computer in one of the lounge areas. A person told us “I can use the internet in the lounge anytime I want”. However, there were no individual activities plan to encourage social interaction and support people who stayed in their room.

We recommend that the provider seek advice and guidance on person centred care planning including activity plans.

People were able to contribute to the assessment and planning of their care when they arrived at the home. If they were returning for a period of respite their care plan was reviewed and updated. Care plans were completed and reviewed by the duty manager who signed to confirm the plan was complete. One person told us, “When you come in they go through your file with you to see if anything has changed and you are happy”.

However, for admissions through hospital discharges and unplanned stays as a result of GP or ‘out of hours’ referrals, the service did not always carry out its own pre-assessment prior to people arriving at the home for respite or reablement. The manager told us that for these referrals a ‘trusted assessor model’ was used, which relied on a pre-assessment completed by a third party, such as a GP or care manager. They said, “Frequently we find these assessments aren’t robust and the information is minimal. On arrival we have to take a reactive response to people’s care and develop our own assessment and care plan on the go”. As a consequence staff across the service may not always have the skills necessary to meet a new person’s needs.

Requires improvement

Is the service responsive?

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Handovers were held at the start of every shift and a hand over sheet was completed. In the mornings night staff handed over to the duty manager and then the duty manager handed over to the care staff.

People were encouraged and supported to maintain their independence. We saw a member of staff supporting a person to use the lift. They provided gentle encouragement to get them to open their hand and push the button. When they did the staff member thanked the person. Staff had developed a good relationship with health professionals to support people who wished to be re-abled back to an independent lifestyle. One visiting health professional told us "This is a very unique place. They really do promote independence". They added "staff are very good at calling us in if there is a problem. They will always phone and ask if they are not sure about something".

The provider sought feedback from people or their families, across both aspects of the service through the use of a quality assurance survey questionnaire. People were asked to complete a questionnaire following each period of respite or reablement. We saw the results from the analysis of all of the questionnaires received during 2014, which were all positive. 94% of people rated the level of care at the home as excellent and the remaining 6% as good. The analysis also compared the results with the previous year. The manager had also received 55 letters of thanks during the previous year from people and their families for the care they had received.

The provider had arrangements in place to deal with complaints Since our last inspection there had been one complaint. This was currently being investigated. The manager explained the action they had taken so far to investigate the complaint. People and relatives knew how to complain. The community reablement team maintained an issue log where issues and concerns were recorded. These issues were reviewed by the manager to ensure they had been responded to and any remedial action taken.

Requires improvement

Is the service well-led?

Our findings

People and relatives told us they felt the service was well-led. One person said "the management are very approachable, they listen. My mother was here and my brother. It is very good". Health professionals and care managers told us they did not have any concerns regarding the leadership of the service, which was well-led. A care manager said "[the manager] is fantastic. If he has any concerns he is straight on the phone to us. He goes over and above my expectations and does a grand job".

The quality assurance system adopted by the provider did not always provide an opportunity for organisational learning or enhance the provision of care people received. The manager maintained a system of audits and reviews on key aspects of the service, such as medicines, care plans, fire safety and audits of accidents. However, these audits were not always robust enough to identify areas for improvement and did not allow the manager or the provider the opportunity to identify any underlying concerns or trends, put in place remedial action and identify training or organisational needs. We raised this with the manager who agreed it was an area for improvement.

The provider's vision and values were set out in the service user's guide. There were posters reinforcing the provider's expectations with regard to people's experiences of the care displayed in the home. There was an opportunity for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities at the end of each period of respite or reablement. People and visitors told us the manager was always walking around the home and was available to talk with them at any time. One relative said "The staff and manager are excellent, I can visit at any time and if I have any concerns they always listen". We observed the manager and staff engaging with visitors and relatives seeking their views and feedback on the service being provided.

Staff across the service were aware of the provider's vision and values and how they related to their work. Regular staff meeting provided an opportunity for the management team to engage with staff and reinforce the provider's value and vision. They also provided an opportunity for staff to provide feedback and become involved in developing the culture of the service. There was an opportunity for staff to engage with the management team on a one to one basis through supervisions and informal conversations. One member of staff told us the manager had "an open door and is very approachable". Another member of staff said "supervisors are always available. They are good at listening".

The service had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. The staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected.

There was a room by room maintenance plan, which identified areas requiring redecoration, repair or replacement. This was overseen by the manager and there was evidence of the work being completed in a timely fashion. For example, during our inspection the maintenance person identified damage to the roof of the conservatory. This was escalated as a priority and repaired the same day.

At the time of our inspection the manager was not registered because the previous registered manager had only recently left. Although not registered the manager understood the responsibilities of a registered manager and was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of the provider's registration. They told us that support was available to them from the provider through the Group Manager for Short Term Services. They were also able to raise concerns and discuss issues with the registered managers of the other short term services owned by the provider.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were at risk of receiving unsafe care because the provider did not have an effective system in place to identify and mitigate risks relating to the health and safety of people using the service.