MCCH Society Limited

Pelican Court

Inspection report

6 Pelican Court
Wateringbury
Maidstone
Kent
ME18 5RJ
Tel: 01622814008
Website: www.mcch.co.uk

Date of inspection visit: 8 and 9 June 2015
Date of publication: 25/09/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
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

Overall summary

The inspection was carried out on 8 and 9 June 2015 and was unannounced.

The service provides accommodation for people who require personal care. The accommodation is set over two floors providing support for up to nine adults with learning and physical disabilities and complex communication needs. Some people were not able to communicate using speech and used body language, signs and facial expressions to let staff know how they were feeling. At the time of the inspection support was being provided to seven people, five people were living on the ground floor and two on the first floor.

The service is located in a village within reach of Maidstone and other towns by public transport. There are shops and village amenities within walking distance.

There was a registered manager employed at the service who had been seconded to another department within the organisation at the time of inspection. A deputy

Summary of findings

manager had been appointed to cover the service whilst the registered manager was away. 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. However Healthcare professionals and a relative told us the service had deteriorated since the registered manager had not been there.

There were not always sufficient staff deployed to meet people's needs. For example we observed that people had to wait when they wanted a cup of tea as there was insufficient staff to attend to them.

Staff knew people well, with many of the staff having worked at the service for a number of years. However, staff were not always considerate and respectful when speaking about people.

Records relating to recruitment kept at the service did not contain the information required under schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and were not available in the service at the time of inspection.

People received their medicines safely and when they needed them. Staff had not consistently followed safe practice around administering and recording medicines given to people.

People's food and drink consumption had been recorded on a daily basis. Staff knew when and how to make a referral to a healthcare professional if they had concerns about a person. However people were not actively engaged with making choices about meals.

Potential risks to people in their everyday lives had been identified, and, had been assessed in relation to the impact it had on people. Staff had not consistently followed the risk assessments which were in place for people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The deputy manager showed that they understood their responsibilities under the Mental Capacity Act 2005 and DoLS. Mental capacity assessments and decisions made in people's best interest were recorded. At the time of the inspection the deputy manager had applied for both standard and urgent authorisations for all seven people who lived at the service.

There was a relaxed atmosphere in the service between people and staff. People's life histories had been documented and we observed staff talking to people about their interests. However, people were not supported to participate in a wide range of activities. People had a weekly activity timetable in place but this did not reflect the activities being offered to people.

People told us that they felt safe. Staff had received training about protecting people from abuse, and they knew what action to take if they suspected abuse. The management team had access to, and understood the safeguarding policies of the local authority.

People's health was monitored and when it was necessary, health care professionals were involved to make sure people remained as healthy as possible.

People's needs were assessed before moving into the service with involvement from family members, health professionals and the person's funding authority. Care plans contained detailed relevant information and clear guidance about all aspects of a person's health, social and personal care needs to enable staff to meet people's needs.

There were systems in place to review incidents and accidents, which were able to detect and alert the deputy manager to any patterns or trends that had developed.

The deputy manager ensured that they had planned for unforeseeable emergencies, so that should they occur people's care needs would continue to be met. The premises were maintained and checked to help ensure the safety of people, staff and visitors.

People's health was monitored and when it was necessary, health care professionals were involved to make sure people remained as healthy as possible.

The complaints procedure was readily available in a format that was accessible to the people using the service. People were able to discuss any complaints with staff through monthly meetings. Complaints were dealt with promptly with all outcomes monitored and recorded.

Summary of findings

Staff told us they felt supported by the management team. Staff were trained to meet people's needs and were supported through regular supervision and an annual appraisal, so they were supported to carry out their roles. People were supported by staff that had the skills and knowledge to meet their needs.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to insufficient numbers of staff and having regards to people's well-being. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff had not consistently followed people's risk assessments to keep them safe from potential harm.

There were not enough staff deployed to meet people's needs.

Staff had not consistently followed safe practice around administering and recording medicines given to people.

Records relating to the recruitment of staff were not available for the inspector to check.

The premises and equipment was adequately maintained with a range of security checks in place.

Is the service effective?

Requires improvement

The service was not always effective.

People were provided with a suitable range of nutritious food and drink but people did not always have a choice about their meals.

Staff had limited understanding in relation to the Deprivation of Liberty Safeguards (DoLS). The deputy manager understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and people's mental capacity to consent to care or treatment was assessed and recorded.

Staff were supported effectively through induction, training and supervision so they had the skills needed to meet people's needs.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were not always considerate and respectful when speaking about people.

People were not always supported or encouraged to develop skills which would aid their independence.

Staff knew people well and understood their changes in mood, posture and sounds and what they were communicating. Staff understood people's preferences, personal histories and the best way to meet their needs.

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's choice of activities to participate in was limited due to restrictions within the service.

Care plans contained detailed information and clear guidance to enable staff to meet people's needs.

The complaints procedure was available and in an accessible format to some people using the service.

People were supported to maintain relationships with people that mattered to them.

Staff made prompt referrals to healthcare professionals when people's needs changed.

Is the service well-led?

Requires improvement 

The service was not always well-led.

The registered manager had been seconded to another department within the company, the deputy manager had been covering the service.

A system was in place to regularly assess and monitor the quality of the service people received, through a series of audits. However, audits completed by the deputy manager had not picked up on observations we made during the inspection.

There was an open and transparent culture, where people and staff could contribute ideas about the service.

The provider sought feedback from people and their representatives and acted on comments made.

Pelican Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 9 June 2015 and was unannounced. The inspection team consisted of one inspector and one 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 by experience had a background in and understanding of learning disability services.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with two people about their experience of the service. We spoke with two care workers, one personal assistant and the deputy manager to gain their views. We asked three health and social care professionals for their views about the service. We observed the care provided to people who were unable to tell us about their experiences.

We spent time looking at records, which included three people's care files, four staff record files, the staff training programme, the staff rota and medicine, policies and procedures, complaint and incident and accident monitoring systems.

The previous inspection was carried out on the 30 July 2013, we had no concerns and there were no breaches of regulation.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the service, one person said "I feel lovely and safe".

There was a safeguarding policy, and staff were aware of how to protect people and the action to take if they suspected abuse. Staff were able to describe signs of abuse and what they would do if they had any concerns such as contacting the local authority safeguarding team. The staff induction included training about safeguarding adults from harm and abuse and staff also received annual training on this topic.

People were protected from financial abuse. There were procedures in place to help people manage their money as independently as possible. This included maintaining a clear account of all people's money received and spent. Money was kept safely and what people spent was monitored and accounted for on a daily basis. People had a lockable safe in their bedrooms, and choose whether to keep their money in the office or in their safe. People were given a choice of where to store their personal possessions and keep their money safe.

Staff were aware of the whistle blowing policy and they had been given a dedicated telephone number to report concerns from the provider. The deputy manager used team meetings and supervisions to reinforce how to follow safeguarding procedures with staff. Staff told us they were confident that any concerns they raised would be taken seriously and fully investigated to ensure people were protected from abuse. They knew they could take concerns to outside agencies if they felt they were not being dealt with by the provider.

Staff told us there was not enough staff and the use of agency staff was high. The deputy manager told us that there had been recent staff sickness which had resulted in an increase of agency staff usage, but they had maintained four staff on duty morning and afternoon. The duty rota confirmed four staff were available during the day, three worked downstairs and one upstairs. Agency staff were being used on a weekly basis. The deputy manager told us, "When agency staff are booked, we request the same people who have worked at the service before, we have regular agency workers we use." Health care professionals told us they were concerned about the level of staffing and high usage of agency staff. Their concerns were regarding the use of 1-1 support, in that people were not receiving the 1-1 support they had been assessed as needing. It was not clear from the rota that people were receiving any 1-1 hours. The deputy manager told us that one person had additional 1-1 support hours but this was not clearly recorded.

At the time of the inspection there were three members of staff working in the downstairs unit supporting five people. One member of staff was upstairs supporting one individual. Later in the day, one person was taken out to a regular activity by a member of staff and this left two staff supporting four people on the ground floor. At certain times people had to wait for support. For example we observed that people had to wait when they wanted a cup of tea as there was insufficient staff to attend to them. One member of staff was completing the health and safety checks and the other was cleaning. We looked at four week's rota's which showed the same staffing levels as the day of the inspection four members of staff on duty on a daily basis. The rota did not evidence how and when people received any 1-1 hours of support.

There were not enough staff to meet people's needs safely at all times. The example above was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment files kept at the service did not contain the information required under schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Of the four file we checked only one had an application form. Three had no proof of identity, four had no references and four had no proof of qualifications. We could not be satisfied that staff had references and checks before starting work due to the lack of records available. The deputy manager told us that all current records had been sent back to the providers head office, these were not available in the service at the time of inspection. The deputy manager was able to talk through the recruitment process which included obtaining suitable references, identity checks and completing a Disclose and Baring Service (DBS) background check and considering applicants health to help ensure they were safe to work at the service. A recent employee confirmed this process had been followed with them.

Inadequate

Is the service safe?

Recruitment information was not available in relation to each person employed. The example above was a breach of Regulation 19 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities).

Staff had job descriptions and contracts so they were aware of their roles and responsibilities as well as their terms and conditions of work. Successful applicants were required to complete an induction programme at the providers head office before working alongside current staff at the service. This was confirmed with a new member of staff and from training records.

Potential risks to people in their everyday lives had been identified, such as personal care, accessing the community, monitoring their health and management of behaviour. Each risk had been assessed in relation to the impact that it had on each person. Control measures were in place to reduce the risks and guidance was in place for staff to follow about the action they needed to take to protect people from harm. Risk assessments were reviewed at the monthly meetings people had with their link worker and updated if necessary, which meant staff had up to date information to meet people's needs and to reduce risks.

However, staff were not always following people's risk assessments. We observed a person assessed as at risk of choking when eating their lunch alone. Risk assessment and guidelines in place stated that the person should be observed whilst eating as they were at risk of choking. We observed staff sitting in another room when the person was eating, which meant that they were unable to observe the person.

Failure to follow stipulated guidelines as stated above was a breach of Regulation 12(2) (b) of the Health and Social Care Act 2008 (Regulated Activities).

Systems were in place to ensure medicines were ordered from the pharmacy on a monthly basis. Staff told us two members of staff checked through all the received medicines each month, recording the date it was received, quantities received and that the medicines matched the medicines administration record (MAR). Clear guidance was in place for people who took medicines prescribed "as and when required" (PRN). Staff were suitably trained and completed an observational assessment with the management team prior to administering any medicines. Staff told us they had completed medicines training but were not able to administer medicines until they had been assessed as competent.

Medicines were stored securely in people's bedrooms. People were supported to take their medicines when required. Each person had an individual MAR showing their personal details and the medicines they were prescribed and when they should take them. However, staff had not followed the procedures for signing the MAR chart once medicines had been given. Four people's MAR charts were checked. Three MAR charts had signatures missing from 25 May, 29 May, 5 June and 7 June 2015. Staff said that the medicines had been given but the staff had not signed to confirm that medicines had been administered. Staff had not consistently followed safe practice around administering and recording medicines given to people.

Staff were observed administering medicines to people without communicating what they were doing. They did not obtain people's consent before administering medicines. A member of staff approached a person who appeared to be asleep and placed a mask of a nebuliser over the person's face without speaking to them. The person appeared startled by this. The same member of staff walked through the lounge where people were sitting saying "You have had your med's", "You have had your ensure (fortified drink)". People were not always spoken about in a dignified way.

We recommend that the provider seeks and follows guidance from the Royal Pharmaceutical Society for the "Administration of Medicines in Care Homes" or equivalent best practice guidance.

Accidents and incidents were recorded via an online system called 'Recordbase'. Staff completed a paper version of the incident form which was then recorded online. Accidents and incidents were investigated by the deputy manager and an action plan was then completed. The senior operations manager was alerted to all accidents and incidents. The system was able to detect and alert the management team to any patterns or trends that developed. All notifiable incidents had been reported correctly. The deputy manager showed us a summary and the total number of accidents and incidents for each

Inadequate

Is the service safe?

person. For example, an incident regarding a person had resulted in an update to their care plan. Important events that affected people's health, welfare and safety were reported and acted on if necessary.

The premises were maintained and checked to help ensure the safety of people, staff and visitors. The staff carried out weekly health and safety checks of the environment and equipment. Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they were reported. Records showed that people's hoists, portable electrical appliances and firefighting equipment were properly maintained. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order.

People had a personal emergency evacuation plan (PEEP). A PEEP sets out the specific physical and communication requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. Staff and people were involved in fire drills, which meant people had an awareness of the fire alarm and what happened if it sounded. People's safety in the event of an emergency had been carefully considered and recorded.

Requires improvement

Is the service effective?

Our findings

People told us when asked if they had a choice of meals "I have what is put in front of me". There was a pictorial menu in the kitchen showing choices for lunch such as soup, beans on toast, cheese and crackers or sandwiches. People were not given a choice of options for their lunch and staff were observed making sandwiches for people. A member of staff was observed describing the taste of two different packets of crisps to people, whilst they made a decision of which to eat. People were offered a choice, but this choice was restricted by the staff to which filling they wanted in their sandwich. People's food and drink consumption had been recorded to monitor people's food and drink intake which was important if people were at risk of dehydration and malnutrition. People had received support from health care professionals regarding fluid and nutritional needs for example; one person has pureed food diet.

We recommend that the provider seeks and provides best practice guidance for supporting and involving people with complex communication needs in meal planning and preparation.

Staff had received training in equality and diversity and the Mental Capacity Act 2005. They were able to describe how and when consent would be requested from people. This had not been consistently followed by the staff who gave people their medicines without asking them if it was alright to do so.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were not always aware of their responsibilities under the Mental Capacity Act (MCA) 2005, and the Deprivation of Liberty Safeguards (DoLS). Staff had received training to understand and use these in practice, but did not completely understand how DoLS affected the people living at the service. Staff told us no one at the service had a DoLS authorisation in place, when in fact all seven people living at the service had DoLS applications or authorisations for restrictions in place. The deputy manager stored the DoLS applications in his office and not in people's personal files. Staff did not have access to this information and were therefore unaware people had the authorisations which were specific to people's needs. People could have been deprived of their liberty without the staff being aware they had been.

We recommend that the service makes the information available to staff relating to the Deprivation of Liberty Safeguards (DoLS).

People and the key people in their lives were consulted before decisions were made. Staff told us when people lacked the mental capacity to make decisions they were guided by the principles of the MCA to ensure any decisions were made in the person's best interests. MCA assessments for less complex decisions such as signing a support agreement between the person and the provider had been completed, followed by a best interest meeting. People's capacity had been assessed on a decision specific basis.

People were supported by staff that had the skills and knowledge to meet their needs. New staff completed a week-long induction at the head office before starting work at the service. This included training in topics such as safeguarding adults, health and safety, Mental Capacity Act, Deprivation of Liberty Safeguards, first aid, moving and handling, food safety and administration of medicines. New staff worked alongside more experienced staff within the service before working unsupervised and followed an in-house induction plan which was specific to the needs of the people living at the service. The deputy manager told us he asked staff questions to check their understanding, which was confirmed by a new member of staff. These had been recorded within the induction book for new staff.

Staff said they had received the basic training they needed to fulfil their role, records at the service confirmed this. Staff received refresher training in a number of subjects to keep their knowledge up to date and current. Staff told us they had requested training in dysphagia (dysphagia is the medical term for swallowing difficulties) to meet a person's specialist needs but this had not yet been arranged. The deputy manager told us a member of staff had been booked to attend this training and in the meantime staff had access to information and guidance from healthcare professionals.

We recommend that the provider seeks and provides appropriate training to all staff to meet specific needs people in the home.

Staff told us they felt supported by the management team. Staff received regular supervision meetings in line with the provider's policy. These meetings provided opportunities for staff to discuss their performance, development and

Requires improvement

Is the service effective?

training needs. The deputy manager also carried out annual appraisals with staff to discuss and provide feedback on their performance and set goals for the forthcoming year.

People's health was monitored and when it was necessary health care professionals were involved to make sure people remained as healthy as possible. A doctor's appointment was made during our inspection following a family members concern about a person. All appointments with professionals such as doctors, opticians, dentists and chiropodists had been recorded with any outcome. Future appointments had been scheduled and there was evidence that people had regular health checks. People had been supported to remain as healthy as possible, and changes in health were responded to promptly. When people had to attend health appointments, they were supported by staff that knew them well and who would be able to support them to make their needs known to healthcare professionals.

Staff had created hospital information books for people to use when they visited hospital. These detailed people's health conditions and information that hospital staff needed to support the person.

Requires improvement

Is the service caring?

Our findings

People told us the staff were caring. A relative told us "Some staff were very good but other staff were lazy". There was a relaxed atmosphere in the service and we heard good humoured exchanges between people and staff. Staff knew the people well, with six staff having worked at the service for a number of years. People looked comfortable with the staff that supported them. Staff knew people's personal histories and were observed talking to people about their family and past interests.

Staff communicated with people in a way they understood. They spoke slowly and clearly with people and answered their questions calmly and patiently. Staff crouched down so they could make eye contact with people. Staff told us about people who had complex communication needs. For people who had less verbal communication, staff understood how to interact with them and people responded with facial expressions or hand gestures. For example, we observed one person point to the choice of crisps they wanted.

We observed that there were good interactions between people and staff and we observed people and staff joking with each other. Most of the time staff spoke with people in a respectful way. Staff had received training in equality and diversity and told us they understood how to treat people with respect. However, staff were not always considerate and respectful when speaking about people. A member of staff told us whilst supporting someone with their meal in the lounge with other people present that "They are end of life care". This did not show a caring or dignified way to describe a person. During medicine administration, we saw that staff showed a lack of privacy and dignity towards people receiving medicines, which did not respect their dignity

People were not always supported or encouraged to develop skills which would aid their independence. For example, one person had their own butter and marmalade which they used every morning for their breakfast. Another person was observed taking the butter out of the fridge and placed it next to the bread waiting to make their own sandwich. A member of staff put the butter back into the fridge and did not provide any explanation to the person as to why they had done this. They did not speak to the person or provide a reason why they were unable to make a sandwich. A relative told us that staff did not engage with people when the opportunity arose. Staff had not promoted people's independence in the service.

We recommend that the provider seek advice and guidance from a reputable source, about promoting people's independence, developing and maintaining their skills.

One person had requested to have their television moved to their bedroom wall. Staff spent time explaining the costs and benefits of different wall brackets. Staff provided information in an accessible way with both written text and photo's to help the person weigh up the options. The person chose the option which suited them and staff purchased the wall bracket.

Everyone had their own bedroom and they had been involved in the choice of decoration. Each bedroom reflected people's personalities, preferences and choice. Some people had photographs of family and friends and pictures of interest on their walls. People had equipment like televisions, radios and music systems. All personal care and support was given to people in the privacy of their own room. Staff explained how they supported people with their personal care whilst maintaining their privacy and dignity. People, if they needed, were given support with washing and dressing. People chose what clothes they wanted to wear, with staff offering choices in a way people could understand.

Staff knew people well and were aware of people's life histories. Each person had a 'My life so far' within their care plans, this detailed people's life histories, details of family members and important events and included photographs. We observed staff talking to people about their family and past activities.

When people were at home they could choose whether they wanted to spend time in the communal areas or time in the privacy of their bedroom. We observed people choosing to listen to music in the lounge with headphones, and spending time in the conservatory which was respected by staff. Some people liked to spend time in their room and other people sat together in the communal lounge chatting. People could have visitors when they wanted to and there were no restrictions on what times visitors could call. People were supported to have as much contact with their friends and family as they wanted to. One

Requires improvement

Is the service caring?

person was out staying with family during our inspection. The staff contacted the family to see how the person was and if they could help with picking the person up. People were supported to maintain relationships with the people that mattered to them.

Requires improvement

Is the service responsive?

Our findings

People were supported to maintain and develop relationships with people that mattered to them. One person told us "I asked to call my brother up, and the staff helped me". People had regular contact with their family members which was encouraged by staff if they wanted to. During the inspection one person had spent the weekend with their family.

People had a weekly activity timetable which included social activities but this did not reflect the activities being offered. One person told us they were not able to attend their exercise class any longer due to transport problems. Healthcare professionals told us that they were concerned regarding the choice of activities being offered to people. Their concerns were regarding the level of activities being offered to people. For example sensory time or cooking and out in the community. A relative told us staff were not imaginative in sourcing activities for people to participate in. The deputy manager confirmed that people had not been accessing the community as often since the house vehicles had been removed, and he had requested that staff look at whether people were eligible for mobility cars. The deputy manager had asked the staff team to think about activities people would enjoy at a team meeting. One person was supported out during our inspection to a regular activity to a day centre. One person told us they had not been able to go out as their wheelchair had been awaiting repair, this meant the person had not been able to access the community whilst awaiting the repair.

People were involved in their care, which was specific to their needs. People with complex communication needs were supported by staff who knew them well. People's needs had been reviewed with the involvement from family members and healthcare professionals. A relative told us that actions had been set at a review meeting but these actions had been continuous over a period of a year. The actions had not been completed and had remained on going from year to year, these included keeping active for health reasons and resourcing activities for the person to participate in.

This failure to provide activities to meet people's individual needs was a breach of Regulation 9 (1) (a), (b), (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed before moving into the service with involvement from family members, health professionals and the person's funding authority. Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs to enable staff to meet people's needs. They included guidance about people's daily routines, communication, life histories, health condition support and pictorial behaviour support information. A person had recently moved into the service. A transition plan had been put in place to ensure the person was fully supported; this included a member of staff who knew the person well transferring to the service to continue supporting the person. The member of staff had worked with the person for a number of years and had a good working relationship with the person's family.

People's care plans were reviewed on a regular basis, changes were made when support needs changed, to ensure staff were following up to date guidance. Some people were not able to communicate using speech and used body language, signs and facial expressions to let staff know how they were feeling. Staff understood people's communication needs well and interpreted what people wanted and what people were saying. People with complex communication needs had detailed individualised communication plans. These included guidance for staff under the following headings, "how I communicate", "the best way to communicate with me", "best places and times to communicate with me" and "how I tell you what I would like". We observed staff following these communication plans and communicating with people in their preferred method.

Staff were responsive to people's individual needs. Staff responded to people's psychological, social, physical and emotional needs promptly. Staff were able to identify when people's mental health or physical health needs were deteriorating and took prompt action. A recent appointment had been made to the doctors following concerns raised by a family member.

A system was in place to receive record and investigate complaints. One person told us "If I am unhappy I would tell the staff and they would help me". People had regular meetings with their link worker; a link worker was a designated staff member who knew the person well. These meetings gave people the opportunity to raise any concerns they may have, which were recorded and dealt

Requires improvement

Is the service responsive?

with promptly. For example, a complaint had been raised about the noise levels. Staff recorded the details of the complaint and had recorded the response and outcome. People were able to express their views and choices and were involved in making decisions about their care.

The complaints procedure was available to people and was written in a format that people could understand. Pictorial complaint leaflets were available within the service. Staff told us they would talk to the deputy manager or personal assistants if they had any concerns or issues, and would support people to complain if they wished to. Staff knew people well and were able to tell if there was something wrong, observing body language for people with complex communication needs. Staff would then try and resolve this. The provider had a complaints policy and procedure which had been followed regarding a recent complaint.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager who had been seconded to another department within the organisation at the time of inspection. The deputy manager was covering the service in the manager's absence. The deputy manager had weekly contact with the registered manager who provided support and guidance if necessary. The deputy manager told us that the registered manager's secondment had been extended for a further three months.

Healthcare professionals told us they felt the service had deteriorated since the registered manager had not been there. This was also confirmed by a relative who told us things were not progressing since the registered manager had been seconded.

The deputy manager was supported by two personal assistants to manage the care staff. Staff understood the management structure of the service, who they were accountable to, and their role and responsibility in providing care for people. People were able to approach the deputy manager when they wanted to. Staff told us that the deputy manager was approachable and very supportive. Staff told us if they did have any concerns the deputy manager acted quickly.

There were some systems in place to regularly monitor the quality of the service that was provided. The deputy manager completed regular audits, such as, health and safety, care planning, staff training and infection control. However, the deputy manager had not completed a medicines audit which would have identified the excess medicines awaiting return. When shortfalls were identified these were addressed with staff and action taken. Environmental audits were carried out to identify and manage risks. Reports following the audits detailed any actions needed and recorded who was responsible for taking the action. Actions were signed off once they had been completed. The audits completed by the deputy manager had not identified what we had observed during the inspection. Action had not been taken to resolve the issues with regards to the lack of activities, and, that some staff were not respectful towards people talking about them rather than to them.

Regular team meetings were held so staff could discuss practice and gain some mentoring and coaching. Staff meetings gave staff the opportunity to give their views about the service and to suggest any improvements. Staff handover's between shifts highlighted any changes in people's health and care needs, this ensured staff were aware of any changes in people's health and care needs.

People's views about the service were sought through meetings, reviews and survey questionnaires. These were written in a way people could understand. Annual satisfaction surveys were carried out across the organisation. The results showed that a high proportion of people were very happy with the support they received. The provider was in the process of sending out new surveys to people, families and health care professionals. People and those acting on their behalf had their comments and complaints listened to and acted on.

There was an open and transparent culture where people and staff could contribute ideas about the service. Observations with people and staff showed that there was a positive and open culture between people, staff and management. Staff were at ease talking with the deputy manager who was available during the inspection.

The provider had a clear vision and set of values for the service which included ensuring everyone is valued for who they are and can live the life they choose. These were described in the Statement of Purpose and Service User Guide. These documents about the service were given to people and their representatives and available on the provider's website. These documents helped people to understand what they could expect from the service. Staff were aware of the vision and values and described how they put these into practice. The deputy manager told us team meetings are used as a way to understand the provider's ethos.

There were a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and to the required standard. Staff knew where to access the information they needed. Care records were up to date, held securely and were located quickly when needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a), (b), (c) HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care. How the regulation was not being met: Failure to provide activities to meet people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulations 12 (2) (b). HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. How the regulation was not being met: Failure to follow stipulated risk assessment guidelines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1).HSCA 2008 (Regulated Activities) Regulations 2014 Staffing. How the regulation was not being met: There were not enough staff to meet people's needs safely at all times.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 (2) HSCA 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed. How the regulation was not being met: Recruitment information was not available in relation to each person employed