Parkcare Homes (No.2) Limited

# Roseneath Avenue

## 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? | **Good** |

# Summary of findings

## Overall summary

This inspection took place on 16 March 2016 and was unannounced. We had undertaken a previous inspection on 26 August 2015. During the previous inspection the home was in breach of two legal requirement and regulation associated with the Health and Social Care Act 2008. We found that appointments had not been made with the chiropodist and dentist for people's needs to be assessed and attended to. We also found that complaints had not been managed appropriately.

Roseneath Avenue is a care home which is registered to provide personal care and accommodation for a maximum of six adults. People living in the home have autistic spectrum disorder. At this inspection there were six people living in the home in their own self-contained flats.

The home had a registered manager. 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.

People were protected from abuse and avoidable harm. Staff knew how to report alleged abuse and were able to describe the different types of abuse. Two staff were unable to tell us they could 'Whistleblow' to external organisations such as the CQC and local authority. Whistleblowing is when someone who works for an employer raises a concern about a potential risk of harm to people who use the service.

We found out of date food in three people's flats. This meant that people may not be protected against the risk of food poisoning or other health complications. People were given choices during meal times and their needs and preferences were taken into account. People's weight were recorded and monitored regularly.

Most risk assessments were updated to reflect people's current needs and took into consideration people's health needs. We found one person who was at risk of choking, there was no specific intervention or guidance to staff on the action that will need to be taken to ensure the risk of choking is minimised. The registered manager told us this will be included.

Systems were not in place to calculate staffing levels contingent with people's dependency levels. We made a recommendation that staffing levels are regularly assessed by the service against people's dependency needs.

We did not find evidence that people's capacity had been assessed and if consent to care was obtained using the Mental Capacity Act 2005 principles.

Most staff had been trained. Although training had been provided in safeguarding and MCA, some staff were not aware on how to whistleblow and the principles of the MCA.

Due to risks to their safety people living at the home were not allowed to go outside without staff or relative accompanying them. Appropriate Deprivation of Liberty Safeguards had been applied for people that required supervision when going outside.

Some staff had concerns about the culture; however we saw the management team were taking appropriate action to address these concerns.

There was a positive behaviour support and traffic light plan for people that demonstrated behaviour which may put people and staff at risk. These plans provided information to staff on how to minimise the risk of behaviours that may challenge the service.

Care plans listed people's support needs and were person centred.

Quality assurance had been implemented to allow the service to demonstrate effectively the safety and quality of the home.

Complaints were recorded and investigated with a response sent to the complainant.

Recruitment and selection procedures were in place. Checks had been undertaken to ensure staff were suitable for the role.  Staff had received induction when starting employment.

People were supported to maintain good health and appropriate referrals to other healthcare professionals were made.

We observed caring and friendly interactions between management, staff and people who used the service. There was an activities programme in place and people participated in activities.

People were encouraged to be independent and their privacy and dignity was respected. People were able to go to their rooms and move freely around the home

Staff meeting were being held regularly.

We identified two breaches of regulations relating to consent and risk management. You can see what action we have asked the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

Some aspects of the service were not safe.

Checks were not being made appropriately to ensure people do not consume food that had expired.

Formal needs analysis was not used to calculate staffing levels by the service.

One person's risk assessment was not updated to minimise the risk of choking.

Staff understood how to identify abuse and who to report to within the organisation. Two staff we spoke to were unaware on who they could report to outside the organisation such as the CQC or the local authority.

Recruitment procedures were in place to ensure staff members were fit to undertake their roles and there were sufficient numbers of staff available to meet people's needs.

Checks had been made to ensure the premises was safe.

### Is the service effective?

**Requires Improvement**

Some parts of the service were not effective.

People's rights were not being consistently upheld in line with the Mental Capacity Act 2005 (MCA).

Although training had been provided in safeguarding and MCA, some staff were not aware on how to whistleblow and the principles of the MCA.

Staff received supervision and were supported by the registered manager.

People had choices with their meals when staff supported them with meals.

Staff supported people with accessing healthcare provisions.

## Is the service caring?

Good

The service was caring.

People's privacy and dignity was maintained.

There were positive relationships between staff and people. Staff treated people with respect and dignity.

Staff had a good knowledge and understanding on people's background and preferences.

Care plans listed people's ability to communicate and we observed staff communicated with people effectively.

## Is the service responsive?

Good

The service was responsive.

Care plans included people's care and support needs.

People participated in activities and their preferences and choice were being taken into account.

Complaints were recorded and investigated appropriately.

## Is the service well-led?

Good

The service was well-led.

Some staff had concerns with the culture of the service. The management team were in the process of addressing these concerns.

There was a clear management structure in place and relatives and staff spoke positively of the registered manager.

The service had a system for monitoring the quality of care with regular audits and action taken were necessary.

Surveys were completed and analysed to make required improvements to the service.

# Roseneath Avenue

**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.

The inspection was carried out on 16 March 2016 and was unannounced. The inspection team comprised of an inspector and a specialist advisor in learning disabilities.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. We also made contact with the local authority for any information they had that was relevant to the inspection.

During the inspection we spoke with one person, eight staff members, the deputy manager and the registered manager. We observed interactions between people and staff members to ensure that the relationship between staff and the people was positive and caring.

We spent some time looking at documents and records that related to people's care and the management of the home. We looked at five care plans, which included risk assessments.

We reviewed five staff files which included training and supervision records. We looked at other documents held at the home such as medicine records, quality assurance audits and staff meeting minutes.

After the inspection we spoke with three relatives and the regional manager.

Requires Improvement

# Is the service safe?

## Our findings

People and some relative told us that people were safe. One person said "I am happy here." A relative told us "I think [the person] is safe there." Despite these positive comments we found that some aspects were not safe.

Assessments were carried out with people to identify any risks and provided clear information and guidance for staff to keep people safe. Assessments were specific to individual's needs such as road safety, railways, and aggression and health conditions. Assessments were regularly reviewed and updated to ensure they were current. Staff had knowledge of the risk assessments and what steps they should take to help keep people safe from harm. One person had a positive behaviour support plan as there was a risk of physical aggression and the support plan listed information to mitigate the risk and listed de-escalation techniques to minimise the risk of harm. However, the risk assessment for physical aggression for the person was not contingent with the behaviour support plan as the risk was listed as 'not applicable'.

Two people had Pica. Pica is when people consume non-food items that have no nutritional value. Some of these non-food items can cause a person to choke if consumed. There was a safeguarding incident where a person had inserted an inedible object in their mouth and was at risk of choking. An incorrect intervention was used by a staff member that would not have prevented the person from choking. We found following the incident that the person's risk assessment had been updated that listed the correct intervention to be used. However, we did not see evidence if staff were trained on using the correct intervention or if a referral had been made to a specialist to minimise the risk of choking during the inspection. After the inspection, the registered manager sent us evidence to show that training in this area had been requested and told us training had been booked. We found that, for another person who had Pica and was at risk of choking, there was no specific intervention or guidance to staff on the action that will needed to be taken to ensure the risk of choking was minimised. We fed this back to the registered manager, who informed us that this will be included on the risk assessment.

During the inspection, we checked people's kitchen and food storage. We found in three people's accommodation, food that had expired, which included vegetables, bread and meat. We informed the deputy manager and these food items were removed promptly. We also found staff had kept their food in one person's fridge. The food was not labelled to show when it was opened, the person the food belonged to and when this should be consumed. The deputy manager told us that checks were made to ensure food was not out of date. We checked one person's record to ascertain if these checks were made, Records showed that although the checks were made, the out of date items were not identified during these checks.

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

On the day of the inspection we saw that there were sufficient numbers of staff available to support people, which corresponded with the staff rota. Most staff told us they had no concerns with staffing levels during the day. We observed staff providing some good care to people and assisted people when required

promptly. We spent time observing care in people's accommodation and there were enough staff on duty to respond promptly to people's requests for assistance.

People were mobile and all the people required either one to one support or two to one support during the day and therefore required regular support and supervision. We saw people that demonstrated behaviour that may challenge. We observed staff using listening and reassurance to support someone to become calm when they were distressed. In a particular instance we heard a person demonstrating behaviour that may challenge the service, which required prompt attention by a number of staff members. This meant that staff who were providing two to one support to a person, was reduced to one to one support for a temporary time as staff attended to the person that was demonstrating behaviour that challenged the service.

One relative and three staff members raised concerns about staff availability at nights. During the night there were two waking staff that provided support to five people, if required. Assistive technology were in place to monitor people's movements, if required for their safety and for the safety of others. We noted that two people living at the service were epileptic and some people may demonstrate behaviour that challenged, which might require the attention of more than one staff. We noted that there was an incident where one person who was epileptic required the support of the waking staff member, during which the other person, who had epilepsy, sustained an injury and staff were not in attendance. Assistive technology was in place for the person who had sustained the injury, however we were informed that the technology was not working. We spoke to the registered manager and regional manager at length and asked what would happen if both people who had epilepsy had seizures or if a person that demonstrated behaviour that challenged the service required the support of more than one staff. We were informed that seizures and challenging behaviours during nights were minimal. However, the regional manager and registered manager decided that another member of staff will be deployed to ensure staff were able to respond immediately if support was required.

We asked the registered manager how staffing levels had been assessed and calculated as people had high care needs. The registered manager told us that there had not been a formal needs analysis and risk assessment to work out staffing levels as this was reviewed by the placing authority. After the inspection we were informed that the service had the correct level of staff during nights as this was dictated by the placing borough following initial assessment made of the people. It is important for the service to assess staffing levels especially for people that require regular supervision and support. Dependency tools can also be used to reassess the staffing levels if people needs and support were to change. which can also be sent to the placing borough if required.

We recommend that formal needs analysis is carried out to assess the required staffing levels at all times.

There was a positive behaviour support and traffic light plan for people that demonstrated behaviour which may put people and staff at risk. The plan listed behaviour of people when they were happy or angry and the steps staff should take to avoid or manage behaviours that challenged the service. The positive behaviour support was regularly reviewed using information on people's behaviour and listed triggers, strategies and de-escalation techniques to ensure the risk of behaviour that may challenge the service and people's safety were minimised.

Staff told us that physical intervention to manage behaviours which challenged the service was always the last resort. One staff member told us, "I do not use restraint." Records showed staff had been trained in handling behaviour that challenged the service. They described how they used de-escalation techniques such as providing reassurance, talking in a calm manner and taking people outside to minimise the risk of harm to people and staff. Staff told us the positive behaviour plan worked well to ensure restraints and

challenging behaviour were minimised.

There was evidence to demonstrate that staff had the correct level of training before administering medicines. One person's care plan that listed the person was to be nursed by staff qualified to administer medicine for epileptic seizures. However, when we spoke to the staff, we were informed that they had not been trained and the person's medicine was managed by another trained staff member on duty. This meant that if the person was to have a seizure and required medicine, there would be a slight delay in the trained member of staff getting to the person. The registered manager told us that the member of staff had recently started employment and had been booked to carry out training in medicine. Records confirmed that there were plans in place to train the staff member.

The home had written procedure for the administration of medicines, which was monitored to make sure that staff followed safe practice. We found medicines had been administered regularly and on time. Medicines were stored in a locked cupboard in people's room. There was a locked cupboard within the locked cupboard for controlled drugs, but no controlled drugs were reported in usage. The home had a policy to sign and date the medicine when it was opened, although we noticed that at times this was not consistently completed.

The staff we spoke to told us that they did not administer any 'covert' administration, and records confirmed this. Staff were aware that if the decision is taken to give medicine covertly, it is not good practice to crush tablets or open capsules unless a pharmacist informs the service that it is safe to do so.

PRN medicines, which are medicines such as paracetamol or medicines used for sedation that is to be administered when needed was not being overused. We observed staff using good communication techniques to re-assure people without the need to use PRN medicines.

Staff and the registered manager were aware of their responsibilities in relation to safeguarding people. Staff had undertaken training in understanding and preventing abuse and up to date training certificates were in staff files. The staff we spoke with were able to explain what abuse is and who to report abuse to within the organisation. Most of the staff also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission (CQC) and the local authority. The provider should note that two members of staff were unable to tell us the external organisations they could report to, should they have any concerns.

Staff files demonstrated the service followed safe recruitment practice. Records showed the service collected references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. Staff members were not offered a post without first providing the required information to protect people from unsuitable staff being employed at the home. This corresponded with the start date recorded on the staff files.

We saw evidence that demonstrated appropriate gas safety, electrical safety, legionnaires and portable appliance checks were undertaken by qualified professionals. The checks did not highlight any concerns.

The home had made plans for foreseeable emergencies. Regular fire tests and evacuations drills were carried out and a fire risk assessment was in place to ensure people were kept safe in the event of an emergency. Staff were able to tell us what to do in an emergency, which corresponded with the fire safety policy.

Requires Improvement

# Is the service effective?

## Our findings

People and relatives told us that staff members were skilled and knowledgeable. The person we spoke to had no concerns about the staff that provided personal care. A relative told us, "They [staff] know [the person] better than anyone else." Despite these positive comments, we found that some aspects of the service were not effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

Training in the Mental Capacity Act 2005 (MCA) had been provided to some staff. However, training record showed that approximately 55.6% of staff had not completed training in MCA, five of the staff we spoke to were not able to explain the principles of the MCA. Staff told us they always asked for consent before providing care and treatment. One comment included "We do always ask for consent." We observed that staff asked for consent before providing personal care. We also observed staff asked for people's consent if they wanted to speak to the CQC inspector or the specialist adviser.

We did not find evidence that people's capacity had been assessed and if consent to care was obtained using the MCA principles. The care plans did not cover the elements of capacity, namely can the person understand, retain, and weigh the information, and make a decision on the information. We found two people were assessed to be either lacking understanding in some area's or require support with understanding 'large decisions', these assessments did not detail specific decisions that people did not have the capacity to make. In one care plan we saw consent to care and there was a section that listed if the person's capacity was assessed, this section was blank. Some people had end of life care plan, which listed people's choice and preferences on end of life care. We found in one person's end of life care plan that a best interest decision was made by their family member on the person's end of life preference. The care plan did not include if a capacity assessment was carried out on the person to make a judgement if the person had capacity to make these choices and preference themselves.

We did not see if people were consulted as to whether or not to keep and take medicines themselves. For example, one person self-administered insulin. However the insulin was locked away. We could not ascertain from the person's care notes, whether this was discussed with the person or if a capacity assessment was undertaken.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We saw people were under Deprivation of Liberty (DoLS) authorisation. DoLS are put in place to protect people's liberty where the service may need to restrict people's movement both in and outside the home. For example, if someone left the home unaccompanied and there may be risk to their safety due to a lack of road awareness, a member of staff would accompany the person. We saw applications were made with the Local Authority for people to be assessed for a DoLS authorisation. This meant that people were not being deprived of their liberty and the service had followed correct protocols.

One person was on a specific diet and there was appropriate information in the persons flat regarding this diet. Staff had a good understanding about the person's diet. Staff told us that people had choices when they assisted them with meals. We saw a meal plan for a person that listed choices for the person. One staff told us, "I give my service user a choice. I show rice, pasta and let [the person] choose." A relative told us, "[The person] does get choices. [They are] on a [specific diet] and they do cater for that."

We noted that one person had a specific health condition that required a nutritious and balanced diet and certain amount of calories that needed to be consumed. The service assisted the person with their meals. Food intake was being monitored for the person and recorded on the daily notes. However, the notes did not fully reflect the amount the person ate. We fed this back to the registered manager, who told us that this will be reviewed.

Staff told us they had received an induction, which included opportunities to shadow a more experienced member of staff and look at care plans. This made sure staff had the basic knowledge needed to begin work. The service had systems in place to keep track of which training staff had completed and future training needs. Most staff told us that they had easy access to training and had received regular training, which they found useful. One staff member told us that training was not regular and when we checked the training records, statistics showed that 60.8% of staff had completed mandatory training. The registered manager told us this was due to staff turnover and new staff commencing employment that have been booked for training. Training needs were discussed during appraisals and formal one-to-one supervision. Most staff had completed essential training that helped them to understand people's needs and this included a range of courses such as, autism, forensic training, handling challenging behaviour and basic life support. We saw evidence that showed staff would be undertaking Makaton training. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. Although training had been provided in MCA and safeguarding, when we spoke to staff, we found that two staff members were unable to explain to us that they could report abuse to outside organisations and another five staff were unable to explain the principles of the MCA.

Staff confirmed they received regular supervision and appraisals. They told us they could talk about concerns and any training needs. Records showed that the home maintained a system of appraisals and supervision. Formal individual one-to-one supervisions were carried out regularly. Appraisals were scheduled annually and we saw that staff had received their annual appraisal in 2015. Staff told us they were supported by the registered manager. One staff member told us, "[The registered manager] is supportive."

During our last inspection we found that the service was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 as appropriate referrals had not been made to dental services. During this inspection we found visits were made to dentists and the outcome and appointments were recorded on people's care plan along with outcome of GP appointments. One staff member told us,

"All of them had an appointment with the dentist." Relatives confirmed people had access to healthcare services, one relative told us, "[The] dentist come[s] in to look after [the person's] teeth" and another relative told us, "[The person] sees the GP as and when [they] need it." The registered manager had also arranged a chiropodist to visit the home regularly to provide care and support to people. Staff confirmed people had access to healthcare professionals particularly if they were unwell. They gave us examples of where they were able to identify if the person was not well and take required actions such as phoning the GP. However, therapeutic approaches were not being consistently developed, designed and implemented into people's support packages with the aid of specialists such as speech and language therapists.

Good

# Is the service caring?

## Our findings

People and relatives told us they were happy with the care people received. One person told us, "Staff are ok." A relative told us, "They [staff] are lovely, they are part of my family." We observed that staff were caring and warm towards people when providing support. We observed when staff were caring when they were helping a person get ready to take the person out. Even though the person found communication difficult, staff offered them choices in clothes and described what they were doing throughout.

Staff told us they build positive relationship with people by spending time and talking with them regularly. Staff told us they had time to spend time and interact with people. We observed that people were treated with kindness and care in their day-to-day care. Staff had a good rapport with people and showed patience and skill at supporting people with behaviour that challenged using de-escalation techniques when people became agitated.

The staff we spoke with demonstrated a detailed knowledge of people as individuals and knew what their personal likes and dislikes were. Staff were able to tell us the background of the people and the support they required. Staff told us that they received information on the needs of people using the service and were given time to read people's assessments, care plans and risk assessments. This helped staff to gain an understanding of the needs of people using the service and how best to support them.

Staff told us that they respected people's privacy and dignity. People could freely go into their rooms when they wanted to and close the door without interruptions from staff and people. A staff member told us, "We knock on [the person] door." Observations confirmed staff respected people's privacy and dignity and knocked on doors before entering. The staff we spoke with understood that personal information about people should not be shared with others and told us that when providing particular support or treatment in people's home, it was not done in front of people that would negatively impact on people's dignity. We did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity. A relative told us, "They [staff] do give [the person] love, respect and dignity and that is because of the lady in charge [registered manager] She watches out for everything, she is very much on the ball."

Staff supported people to be independent in their day-to-day lives. Staff told us that people were encouraged to be as independent as possible. We observed a staff member encouraging a person to eat by themselves as a result the person ate by themselves. People had their own accommodation and we observed people were able to move around independently and go to the manager's office, communal area, hallways and garden if they wanted to.

The service had an equality and diversity policy. We observed that staff treated people with respect and according to their needs such as talking to people respectfully and in a polite way. The staff members we spoke with told us that they treated people equally. Cultural and religious beliefs were discussed with people. Their preferences were recorded in care plans. We also saw documentary evidence that people were able to visit holy places for worship and staff confirmed this.

Care plans listed how to communicate with people. For example, one person's plan listed that staff maintain eye contact with the person when speaking. Care plans provided detailed information to inform staff how a person communicated and listed people's ability to communicate. There was a 'communication dictionary' that listed how people expressed different types of emotion such as when they were happy or sad. Relatives had no concerns with staff ability to communicate. We observed staff made use of body language, hand gestures and employed other methods of communication to support people with non-verbal communication to have a voice and maintain choice and control. We observed staff demonstrated good communication with a person about football and tried to engage with the person in a kind and compassionate manner.

Good

# Is the service responsive?

## Our findings

Care plans were person-centred and reflected people's individual needs, goals and preferences. They provided clear information for staff about how to provide care and support in the way the person preferred. We found that care plans had been reviewed regularly to ensure that they continued to reflect people's needs.

Records showed pre-admission information had been completed. An assessment was carried out to identify people's support needs and they included information about their medical conditions, behaviour, communication and their daily lives.

Each person had an individual care plan which contained information about the support people needed. There was a section called 'What would you like the staff team to know about you in order to make you feel comfortable, enabled and cared for' that listed people's support needs. There was a section called 'Things I am good at' that provided information on what people enjoyed doing and their abilities. We found that most people or their family members had input into the care plans and choice in the care and support they received. Care plans were signed by people or their relatives to ensure they agreed with the information in their care plan. Care plans we reviewed had a personal profile outlining the person's support needs, next of kin, identity, health condition and medical history. There was an autism profile that listed people's ability in areas such as communication, and social interaction. These plans provided staff with information so they could respond to people positively and in accordance with their needs.

There was a key worker system in place. A key worker is a staff member who monitors the support needs and progress of a person they have been assigned to support. Reviews were undertaken regularly with people, which included important details such as people's current circumstance and if there were any issues that needed addressing.

A positive behaviour therapist provided guidance to staff on how to support and respond to people with behavioural difficulties. Incidents affecting some people were recorded and analysed to develop strategies for staff to respond effectively and minimise the risk to behaviours that may challenge the service.

There was also a daily log sheet and communication book, which recorded key information about people's daily routines such as behaviours and the support provided by staff. Staff told us that the information was used to communicate between shifts on the care people received during each shift.

People were supported to engage in activities. We observed that notices about activities were displayed at people's flats that we visited. During the inspection we observed a staff member doing manicure with a person and regularly interacting with the person and people going outside with staff members for a walk or to the day centre. A staff member told us, "We take her out a lot." A relative told us, "[They] get walked to the park every day, they give [them] activities." People had an activity planner that listed the types of activities they will be participating in. In one person's care plan we found that the person enjoyed puzzles and when we visited the person's flat, we observed a puzzle had been completed on the person's table. The deputy

manager told us staff had completed the puzzle with the person, before going to the day centre. The provider should note when we spoke to the relative of a person, they told us that updates had not been provided on what activities their family members had participated in. We found in people's care plans that the activities were not recorded in full such as the type of activities people participated in and if they enjoyed the activities.

During our last inspection we found that the service was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 as relatives had complained that staff were not sufficiently responsive to their complaints and concerns and communication was poor. We looked at the complaints folder and saw that there had been two complaints since our last inspection, which had been investigated, and a response provided to the complainant and an apology was offered where necessary. A relative told us, "I never had any concerns." Staff were aware on how to handle complaints and the registered manager told us all complaints were taken seriously and a full investigation was carried out if needed.

People were supported to maintain relationships with their friends and families. Relatives told us that they could visit their family members at any time. Staff told us that they also supported people to make visits to their families' homes. A relative told us, "[The person] comes home every weekend and [the person] is very happy and happy to go back."

Good

# Is the service well-led?

## Our findings

Some staff members told us that the culture within the home was not open and inclusive. We fed this back to the registered manager and regional manager, who were aware of these concerns and told us the action that have been taken to address the cultural issues at the home. The regional manager told us that regular meeting had been held with staff by members of the senior management team to discuss and address any concerns staff may have to ensure the culture within the home was open, transparent and inclusive. A social professional told us, "We are aware that the manager is committed to improving performance of all staff."

We found regular audits and checks had been carried out by the manager, members of the providers quality team and the regional manager. This included an infection control audit, monthly safety checks, finance audits, complaints and a medication audit. We saw that audits had been carried out by member of the senior management teams using the CQC key questions (Is the service safe, effective, caring, responsive and well led?). These audits highlighted areas of best practice and where improvements were required.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The home carried out an annual satisfaction survey of with relatives of people who used the service. The result of the survey was positive. Systems were in place to carry out annual surveys with staff members. This was not completed last year due to minimal number of staff completing the survey. The regional manager told us that a survey will be completed this year for staff and showed us evidence to support this. The regional manager told us that the surveys were used to identify good practice and also if there were any concerns.

People and relatives spoke positively about the management of the home. The person we spoke to did not have any concerns about the management team. We observed the registered manager and deputy manager assisted people when asked and the interactions were friendly and caring. A relative told us, "I feel the [registered manager] is very good" and another relative told us, "[The registered manager] is an absolute diamond, she is brilliant. If she left I would be devastated."

Staff were very positive about the registered manager. One staff member told us "[The registered manager] is good." We saw records of regular staff meetings were staff were encouraged to participate. During these meetings staff discussed concerns, people that lived at the service, activities and working together as a team. Minutes of the meeting were available for staff that were unable to attend to read, if required.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>Care and treatment was not always provided with the consent of the relevant person as the service was not always acting in accordance with the Mental Capacity Act 2005. (Regulation 11(1)(3)) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users health (Regulation 12(1)(2)(a)(b)) |