

The Frances Taylor Foundation St Raphael's

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

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

Summary of findings

Overall summary

This inspection took place on 26 January 2016 and was unannounced. The service was last inspected on 11 July 2013 and at the time was found to be meeting all the regulations we looked at.

St Raphael's provides accommodation and personal care for up to 21 adults with a learning disability. It is divided into three units where people are accommodated according to the level of their needs. There were 21 people living at the service at the time of our inspection, including three people living with dementia.

There was a registered manager in post at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and we saw there were systems and processes in place to protect people from the risk of harm. However, important information about an identified risk for a person who used the service had not been communicated to a visiting activity officer.

The storage of medicines was disorganised. There was no temperature monitoring on the medicines fridge, and there was no protocol in place for medicines prescribed "as required".

A range of activities were provided both in the home and in the community. However, there were no activity plans displayed in the home, and some people were not supported to undertake activities of their choice.

People told us they enjoyed the food offered at the service and their likes and dislikes were recorded in their care plans, however we did not see evidence that people were consulted or involved in developing menus, and those were not displayed.

There were enough staff on duty to meet people's needs at the time of our inspection. The registered manager was undertaking a recruitment drive to cover staff vacancies and required the use of agency staff to ensure people's needs were met. Checks were carried out during the recruitment process to ensure only suitable staff were employed.

Staff had undertaken training on the Mental Capacity Act 2005 (MCA) and were aware of their responsibilities in relation to the Deprivation of Liberty Safeguards (DoLS). Records showed that people had consented to their care and support.

Staff received effective training, supervision and appraisal. The registered manager sought guidance and support from other healthcare professionals and attended workshops and conferences in order to cascade important information to staff. This ensured that the staff team were well informed and trained to deliver

effective support to people.

Staff were caring and treated people with dignity, compassion and respect. Care plans were clear and comprehensive and written in a way to address each person's individual needs, including what was important to them, and how they wanted their care and support to be delivered. We saw that people were cared for in a way that took account of their diversity, values and human rights.

People, staff, relatives and stakeholders told us that the management team were approachable and supportive. There was a clear management structure, and they encouraged an open and transparent culture within the service. People and staff were supported to raise concerns and make suggestions about where improvements could be made.

The provider had effective systems in place to monitor the quality of the service and ensure that areas for improvement were identified and addressed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told 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?

The service was not always safe. Important information about an identified risk for a person who used the service had not been communicated to a visiting activity officer.

The storage of medicines was disorganised. There was no temperature monitoring on the medicines fridge, and there was no protocol in place for medicines prescribed "as required".

There were enough staff available to provide timely support to people. Checks were carried out during the recruitment process to ensure only suitable staff were employed.

Requires Improvement ●

Is the service effective?

The service was not always effective. The menu planner was not completed daily and it was not routine to ask people about their preferred choice of meals.

Where they were able, people had consented to their care and support. The service had policies and procedures in place to assess people's capacity, in line with the Mental Capacity Act (2005).

Staff received effective training, supervision and appraisal.

Staff supported people to access healthcare services and liaised closely with healthcare and social care professionals.

Requires Improvement ●

Is the service caring?

The service was not always caring. Staff did not always use accessible means to communicate with people who used the service and there was a lack of creativity in this area.

Feedback from people and relatives was positive about both the staff and the management team. Staff were observed to interact with people in a caring and respectful way and people told us they felt cared for by all the staff. Healthcare professionals told us that people using the service were being well cared for.

Care plans contained information about people's backgrounds

Requires Improvement ●

and their likes and dislikes. People were supported with their individual needs in a way that valued their diversity, values and human rights.

Is the service responsive?

The service was not always responsive. A range of activities were organised, either in house or in the community. However there were no activity plans displayed in the home and some people were not supported to undertake activities of their choice.

People's individual needs were identified and met when their care and support was being assessed, planned and delivered.

People and their relatives were involved in the planning of their care.

People were encouraged to express any concerns and complaints were investigated and responded to appropriately.

Requires Improvement ●

Is the service well-led?

The service was not always well-led. Quality audits had not always been effective in highlighting concerns in order to mitigate risks to people's safety.

At the time of our inspection, the service employed a registered manager.

People, relatives, staff and stakeholders found the management team to be approachable, supportive and professional.

There were regular meetings for staff, managers and people using the service which encouraged openness and the sharing of information.

Requires Improvement ●

St Raphael's

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 26 January 2016 and was unannounced. The inspection was carried out by one inspector, a Specialist Advisor (SPA) who specialised in working with adults with a learning disability, one pharmacist SPA 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 for this inspection had experience of caring for a person with a learning disability.

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 we held about the service, including notifications we had received from the provider and the findings of previous inspections.

During the inspection, we spent some time observing support being delivered to help us understand people's experiences of using the service. We also looked at records, including five people's care plans, three staff records and records relating to the management of the service. We spoke with 11 people who used the service, seven care staff including the registered manager, three external staff contracted to deliver activities and a visiting healthcare professional.

Following our visit, we spoke with five relatives to obtain their views about the service.

Is the service safe?

Our findings

It was unclear how essential information in care plans and risk assessments was communicated and put into safe practice. For example, during the inspection we observed a service user being given a cup of tea and a biscuit by a visiting activity officer, yet the person's care plan and risk assessment clearly stated they had recently been assessed by a speech and language therapist and due to risk of aspiration on normal fluids were only supposed to be offered thickened fluids and pureed meals. This could have had serious consequences for the person using the service.

Where there were risks to people's safety and wellbeing, these had been assessed. Detailed person specific risk assessments and plans were available and based on the individual risks that had been identified at the point of initial assessment. Each risk was analysed, scored and controls were in place to minimise the risks. However the service appeared to only update individual risk assessments and other care plan documents every 3 months. These had last been completed in November 2015. Whilst this may have been an appropriate time interval for some of the risks identified, there were risks related to the condition and dietary needs of one person who used the service that should have been reviewed more regularly as the person's health was recorded as having deteriorated. This was particularly evident from the person's weight chart that showed a weight loss over many months. The service did not have mechanisms in place to be able to assess when a person's care plans and risks needed reviewing more regularly.

In another person's records it was recorded that they should only use their wheelchair for outdoor use yet it was evident the person had been supported by staff to use their wheelchair to get to and from the activity session. This showed that the service did not have a clear process in place to ensure essential information related to keeping people safe and ensuring their well-being was clearly communicated, especially for agency, external and newly recruited staff.

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

We discussed this breach with the registered manager, and saw that they took immediate steps to develop a one page document which included important information about individual people's needs and guidelines about how to meet those needs. The registered manager told us that this document would be readily accessible for new and external staff.

The home had a medicines policy. All medicines were secure but spare stocks were kept in several locked filing cabinets and were therefore not as well organised as they could be to prevent risks of error in selection and overstocking. No temperature monitoring was carried out on the home's medicines fridge to ensure the potency of medicines requiring cold storage. We discussed this issue with the registered manager and saw they took immediate steps to address this.

Many people were not able to express their needs and we saw no protocols in place for medicines prescribed for pain relief or to help mood or changes of behaviour on an "as required" basis. For example

pain assessment tools, which would help staff identify when a person might need pain relief. We discussed this with the registered manager who told us they would address this without delay.

We noted on the MAR charts that there were several omissions in recording receipts of medicines and stocks carried forward from the previous medicines cycle. This meant that it was often difficult to audit stocks and check if records were accurate. We discussed this issue with the registered manager and they told us they would address this immediately. Of the 10 samples we were able to audit, all were accurate. This meant that we were assured that these medicines were being given as prescribed.

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

MAR charts were completed with no omissions in the recording of administration. Medicines were supplied in a dosage system and we could see that all were given as instructed. We observed a person who used the service being supported with their medicines and saw that two staff members were involved in the process. The MAR chart was signed and witnessed as per the home's procedures.

All people in the home had records of their currently prescribed medicines on their Medicines Administration Records (MAR) charts and copied prescriptions. This meant that staff knew what medicines were prescribed for people. We saw in the care plans we viewed that medicines profiles had been updated and on all the MAR charts the person's allergy status was clearly stated so that the appropriate medicine could be prescribed safely.

We noted that staff were recording variable doses such as one or two accurately so that the prescriber could determine the effectiveness of the medicine.

Many people were prescribed creams and ointments and details of where to apply them were recorded on the MAR charts.

Staff received training in the administration of medicines and they were also provided with annual training updates. Training records we looked at confirmed this. We saw that competencies of staff were assessed during the induction period and we were told that further assessments took place if concerns were identified

We heard that the home's GP visited weekly and saw that notes of their visits were recorded in the care plan. We saw evidence of review of medicines by the home's GP and also by visiting psychiatrists and neurologists. We saw a support plan for one person with a serious medical condition and saw that it was reviewed every three months.

People we spoke with all said they felt safe and were able to talk to staff if they felt unsafe. One person said, "I'm happy here and feel safe, people are kind to me." Another person said, "I am happy here, this is my home and I feel safe." However, we needed to explain what the word 'safe' meant and give examples of when they might not feel safe. A relative told us they believed their family member was safe and said, "I visit my [relative] once a month and she is always very happy, yes my [relative] is safe and I have always found staff wonderful." Another family member said, "My [relative] is very safe and happy at St Raphael's and I am happy with everything." We saw in people's meeting minutes that they were asked what they would do if people were mean to them. All people asked said they would tell the management.

Staff told us they kept people safe. There was a safeguarding policy and procedures in place and staff were

aware of these. Staff we spoke with were able to explain the basics of keeping people safe and safeguarding vulnerable people from abuse. Staff told us they undertook training in safeguarding as part of their induction and training records confirmed this. One staff member said, "Residents are safe and we get regular training here on safeguarding and safety." A healthcare professional told us, "People are kept safe here, they are very well cared for, I have no concern for their safety." The registered manager raised alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They also notified the Care Quality Commission (CQC) as required of allegations of abuse. The registered manager worked with the local authority's safeguarding team and carried out any investigations. Management plans were developed and implemented in response to any concerns identified to support people's safety and wellbeing.

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the staff and people using the service as required, and involved healthcare professionals when needed. A healthcare professional told us that the staff were "excellent at contacting us when people need us." A member of staff told us that management were visible and "hands on." All incidents and accidents were recorded and analysed by the registered manager and included an action plan and a post-incident report. Minutes of staff meetings showed that the registered manager discussed all incidents and accidents that had occurred during the month with staff and included what actions had been taken to reduce the risk of re-occurrence.

The provider had a health and safety policy and procedure in place, and staff told us they were aware of these. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. A general risk assessment identified the hazards, who might be harmed and how, what was already in place, and what further action was necessary.

The service had taken steps to protect people in the event of a fire, and we saw that a risk assessment was in place. The service carried out regular fire drills and fire alarm tests and staff were aware of the fire procedure. People's records contained personal emergency evacuation plans (PEEPS).

There were enough staff on duty on the day of our inspection, and the registered manager told us they ensured that there was always a full team on duty to meet people's needs. They told us that they had employed new staff recently but as some staff had left, they were undertaking another recruitment drive to cover vacancies. The service employed a number of agency staff, although the registered manager told us they were regular ones who were familiar with the service. This ensured stability and continuity of care.

Recruitment practices ensured staff were suitable to support people. This included checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working for the service. This included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check such as a Disclosure and Barring Service (DBS) checks were completed.

Is the service effective?

Our findings

We spent time observing a mealtime and saw that this was a great social opportunity for people to help each other and to interact. However, there was no choice regarding the lunchtime meal and the menu planner on the fridge was blank. The staff member on duty confirmed that the menu planner was not completed daily and it was not routine to ask people about their preferred choice of meals. When asking people what they were having later for tea nobody using the service was able to tell us. A number of the people we spent lunch with could easily have been more involved in having a choice and undertaking roles/responsibilities around mealtime activities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's care plan indicated they were involved in the weekly menus and the shopping for healthy fruit and vegetables. The member of staff on duty worked on their own at lunchtime with nine people who used the service including one person who required support with eating. The staff member was organised and related well to people's wishes and needs as they were familiar with them.

The service recognised the importance of food, nutrition and a healthy diet for people's wellbeing generally, and as an important aspect of their daily life. One person who used the service told us, "I get nice dinners here and enjoy the food, I get lots of tea and juice" and another said, "The food is nice and I choose my dinners." A relative told us that "Staff are great though I would like to see more fruit and vegetables offered."

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. The provider and staff understood the principles of this legal framework. People's care plans recorded the types of decisions they could make for themselves and the support they needed when they could not do so. Staff were observed to support people taking into account their individual needs, however, staff did not always utilise accessible communication to support people getting the right information and making an informed choice.

In one person's care plan and health action plan file there was an 'exemption' form (designed by the organisation) that stated that the person was not able to fully inform their plans. This was a general form and from speaking with the person it was evident that there were a number of elements of their care plan and health action plan that they could be fully involved in. A relative told us they were involved in the reviews of care plans and we saw evidence of this in the documents we looked at.

Decisions taken in people's best interests were recorded and showed that everyone involved with the person's care had been consulted. We saw staff encouraged people to make decisions where they were able to, such as what they wanted to eat and drink and how and where they wanted to spend their time. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection several people had their freedom restricted and the registered manager told us and we saw evidence that they had submitted the applications to their local authority. The provider had therefore acted in accordance with the Mental Capacity Act, 2005 DoLS.

People were supported by staff who had appropriate skills and experience. Staff we spoke with told us they had received a thorough induction when they started to work for the service. They told us that this included training and working alongside other staff members. The subjects covered during the induction included safeguarding, health and safety, first aid, medication, food hygiene, moving and handling and infection control. This included training specific to the needs of the people who used the service and included Mental Capacity Act (MCA), dignity in care and dementia awareness. The registered manager told us that staff undertook online and classroom based training. Staff had obtained a National Vocational Qualification (NVQ) in care and the registered manager told us they were planning to start introducing staff to the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Training records confirmed that staff training was delivered regularly and refreshed annually. This meant that staff employed by the service were sufficiently trained and qualified to deliver care to the expected standard.

During the inspection we spoke with members of staff and looked at staff files to assess how they were supported within their roles. Staff told us and we saw evidence that they received supervision from their line manager every two months. The registered manager told us this provided an opportunity to address any issues and discuss any areas for improvement. This included reviewing people's sickness records and identifying individual development plans. Staff also received a yearly appraisal. This provided an opportunity for staff and their manager to reflect on their performance and identify any training needs.

People and relatives told us the service was responsive to their health needs. One staff member said, "We work with external agencies such as health to make sure people's health needs are met." Relatives told us that staff supported people with their healthcare needs and kept them informed of outcomes of appointments. Healthcare appointments included medical reviews, hearing and dental appointments. The care plans we looked at contained individual health action plans. They contained details about people's healthcare needs and included information about their medical conditions, medicines, dietary requirements and general information. Records showed that advice from relevant professionals was recorded, actioned appropriately and regularly reviewed.

The house was large and had not been modernised for some time. There were no visual photos of staff on display in the reception area. Bedrooms were personalised but décor was poor and needed updating. The registered manager told us that they were undertaking a lot of work to improve the environment and we saw some work in progress on the day of our inspection. This included a new kitchen which we were told would have accessible work surfaces for people to be involved in cooking. There were very few bedroom doors with personalised name plates. Many doors were not visually signed which could cause confusion for people with a learning disability and those living with dementia. We saw areas of the home cluttered with various equipment and boxes which made the home look untidy and unwelcoming.

We recommend that the provider seeks relevant guidance to improve the environment in order to meet the needs of people with a learning disability and those living with dementia.

Is the service caring?

Our findings

People and their relatives were complimentary about the care and support they received. One person told us, "Staff are lovely and [registered manager] is my best friend, staff are very caring and help me a lot" and another said, "I like it here and would tell staff if I was not happy." One relative we spoke with told us they were happy with the care delivered to their family member and said, "Staff are wonderful. We like the Catholic ethos of the home as church is very important to my [relative], staff are caring and I have no concerns." Another relative said, "Staff are very caring and they really do care for all the people there as it cannot be an easy job." However some people suggested some improvements. One family member said, "Staff are caring though I would like to see more stimulation from staff and more engaging with the people, I have seen good staff leave and new staff seem to struggle with interaction, maybe they need more training and guidance on interaction with people with learning disabilities."

We observed the majority of staff being caring and compassionate with person centred focused communication and showing respect for people who used the service. A minority of staff (agency) appeared quite passive in their behaviour particularly during activity sessions where they did not actively join in and engage with people.

We observed staff did not always use accessible means to communicate with people who used the service and there was a lack of creativity in this area. For example, a number of people using the service used a range of sounds and gestures rather than spoken words and from care plans it was evident that some staff recognised and understood what was being communicated because they had built up a good relationship and knowledge of the person and how they chose to communicate. One person's care plan included a "communication passport" which had been created by a Community Learning Disability Therapist (CLDT) and a language therapist. This contained detailed guidance for staff to communicate with the person, such as the use of touch signs. The senior team also ensured that staff who spoke the same language as this person were involved in delivering their care and support so that their communication needs were met. Another person's care plan stated that staff should be encouraged to use Intensive Interaction with them, however, on asking the manager it was established that staff had not received training in Intensive Interaction.

We observed all staff to be respectful of the privacy and dignity of people. However some people using the service used continence pads and on a tour of the service these were clearly displayed in bedrooms (sometimes multiple packs stored in full view of people using the corridor). This had the potential to have compromised people's dignity.

People looked well dressed and groomed and told us they were supported with choosing their clothing and hairstyles. Staff told us they aimed to promote people's independence and encouraged them to make daily decisions about the way they wished to live their lives.

We recommend that the provider seeks relevant courses for staff to undertake to ensure that they meet the communication needs of people using the service.

Is the service responsive?

Our findings

Staff told us care plans were written in cooperation with people using the service and their family members. A relative and records we viewed confirmed this. A healthcare professional told us that they were involved in the planning and reviewing of people's healthcare needs and said that staff were responsive to any advice and instructions they gave them. They said, "The staff and management are excellent. They always involve me or my colleagues when they have a query or a concern regarding the care of people."

The care plans we saw were clear and comprehensive and were available in an easy read format, using pictures. They captured individual needs in great detail and were split into sections which included support, health and wellbeing, health and safety, and "me and my life". In addition, we saw that each file had a section named "this is me". This was a document written from the person's perspective, and included every aspect of the person's life such as their background, likes and dislikes, wishes, fears, and how they wanted their care and support to be delivered. This included guidelines such as "encourage me to talk freely about my feelings" and "spend one to one time with me" for a person who had a tendency to get angry and agitated.

People's records contained "hospital passports". This was a document which provided important information in the event of a hospital admission. This included people's healthcare needs, such as current medicines, allergy status and background history. It also contained information about people's level of comprehension and behaviours that may be challenging or cause risks. This showed that the service had taken steps to ensure that people's needs were met according to their needs and wishes.

Many people living at the service were able to undertake tasks such as laundry, cleaning their rooms and helping with cooking and serving meals. However we saw very little evidence of this taking place. There were missed opportunities to promote the skills for daily living within the home.

There were rules for all about no access to the laundry and opportunities to be more involved in domestic activities as well as a lack of assessment of daily living skills which meant some people were not fulfilling their potential. However we saw that one person had been encouraged to help with household chores and was the waitress for the organised coffee mornings. The registered manager also showed us that the deputy manager had started to meet with people who used the service to develop a list of domestic activities for them to take part in.

We saw evidence that people living at the service took part in activities arranged at the home and in the community. The care plans we looked at had identified individual activity plans for people. This included a person who had recently joined a leisure centre and were using the gym and swimming pool. However we did not see any activity plans displayed in the home which meant that people may not have been aware of what was going on, or what had been planned for the day or the rest of the week. One visitor said, "We had a few teething problems at first but my friend has settled down well, I am not convinced that they are doing all they can for [person] but I am talking and working with the home to improve things. They don't take [person] to church every Sunday and [person] loves the church and I think it's a staffing issue." Many residents attended day centres in the community and were supported to undertake their personal shopping.

We saw in people's meeting minutes that activities were discussed and that people's suggestions for future activities included bowling, Kew Gardens and craft fairs. Current activities taking place included yoga, drama, themed activities and cookery sessions. We witnessed a cookery session going on during our visit.

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any risks that were involved in managing the person's needs. The care plans we looked at contained health action plans designed to capture people's physical and emotional needs. They were up to date and consisted of detailed descriptions of people's behavioural traits, their likes and dislikes and best methods of communication. They included sections such as "what people like and admire about me", "how best to support me" and "what is important to me".

The service was responsive to people's cultural needs and care plans we viewed recorded people's needs clearly. This included one person who chose not to practice their faith but were regularly consulted during reviews in case they changed their mind. Care plans contained information about people's faiths and what it meant to them so that staff would understand and respect their diverse needs and wishes. This included cultural needs, festivals they celebrated and food they chose to eat.

People had opportunities to build and maintain friendships within their peer groups in the service and there were also some external activities and opportunities such as a cookery activity where other people with learning disabilities came into the service to participate. On the day of our inspection we witnessed several activities being delivered by visiting activity officers. This included an aromatherapy session. The sensory group involved 10 people who used the service and three staff members and was a morning long activity. The staff member in charge of the activity explained that everyone had their own specific aromatherapy oils and treatment card. The treatment cards were observed with consent forms.

People were supported to maintain contact with their family and friends and there was evidence of this in people's bedrooms and their person specific planning folders. Relatives we spoke with confirmed that they were encouraged to be involved and maintain good contact with their family members.

People told us they could tell staff and the registered manager if they had a complaint. A relative told us, "I do like the home it has a nice feel about it but I feel the agency staff let them down at times." The service had a complaints procedure in place and this was available to relatives and staff. An easy read version was available to people who used the service. A record was kept of complaints received. Each record included the nature of the complaint, action taken and the outcome. Where complaints had been received, we saw that they had been investigated and the complainant responded to in accordance with the complaints procedure. This included a complaint from a relative during a visit. We saw evidence that the registered manager had replied in writing and offered to meet for a discussion. An action plan was developed and actions recorded as achieved. We saw that this was discussed during a staff meeting. This indicated that the service was responsive to complaints and ensured they were addressed and resolved in a timely manner.

We recommend that the provider seek guidance relevant to the provision of activities specific to the needs of people with a learning disability.

Is the service well-led?

Our findings

The registered manager told us that the company operated an internal managers' audit system whereby managers of different services carried out audits of each other's services. Audits included areas such as care plans, service user involvement, risk assessments, medicines, incidents and accidents, staff records and policies and procedures. At the end of each report, an action plan was formulated from the findings. We saw that recommendations were taken on board and addressed by the registered manager. This included a recommendation to increase the frequency of staff supervision. However, it was clear from the evidence gathered during our inspection that audits had not always been effective in highlighting concerns. This resulted in the service being unable to effectively assess, monitor or take action when necessary to mitigate against risks to which people had been exposed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were complimentary about the registered manager and the senior staff and told us they were all approachable. One person told us, "I love [registered manager]. She is my best friend and everyone is nice to me." Another person said, "I like all the staff and the manager is lovely." One relative told us, "I love St Raphael's and am blessed that my [relative] is there. Really good management." Another said, "My [relative] is happy and I can relax. The manager is a lovely person and they are always respectful to people." A visitor we spoke with said, "I feel it's well led and overall it is good though there is always room for improvements."

Staff spoke positively of the manager and felt highly supported. They told us that there was a good team ethos and culture and that the management team could be approached at all times. One newly recruited member of staff said they had been made to feel very welcome and other staff were always happy to work alongside them if they needed support. Staff said they were able to raise concerns and suggest ideas. All the staff we spoke with said that the manager was visible. A healthcare professional told us they had trust in the staff and the management team. They said, "The whole team is very good, from management to staff. This service is well-led."

The registered manager had been in post for three years and was supported by a deputy director who was on site, a deputy manager, a team leader and a senior care worker. They told us that the whole team was committed to providing good quality care and support to people.

Staff told us they had monthly meetings and records confirmed this. The items discussed included safeguarding, incidents and accidents, health and safety, training, and any other issues regarding people living at the service or staffing issues. Outcomes of complaints, incidents and accidents were discussed so that staff could improve their practice and implement any lessons learnt from the outcome of investigations. We saw evidence that at the end of each meeting, an action plan was agreed which included any actions needed, by whom and the date of completion. Meeting minutes were made available to all staff to ensure they read and understood the content. In addition to staff meetings, the registered manager organised staff

unit meetings and senior meetings.

People who used the service were supported to take part in monthly meetings. They were also given the opportunity to have one to one meetings with their keyworker. A keyworker is a designated member of staff who has responsibility for one or a small group of people who use the service, and to be the first point of contact when liaising with them, their relatives and healthcare professionals. People confirmed that they took part in those meetings and found them useful and informative. Some of the issues discussed in people's meetings included holidays, activities and safeguarding.

The registered manager told us they issued a monthly report to their service manager with detailed information about a range of areas such as recruitment, staffing issues and issues relating to people using the service, health and safety, repairs and maintenance. This indicated that there was a good communication system within the service which encouraged and valued the sharing of information.

People, their relatives and staff were encouraged to provide feedback about the service through quality assurance surveys. We saw a range of surveys which indicated an overall satisfaction. People who used the service were given easy read surveys which were pictorial, colourful and clearly written. The registered manager evaluated these surveys to gather information about how people felt about the service and to identify and address any areas for improvement. Some of the comments we saw included, "Very pleased with everything", "I am always warmly greeted on my visits", "Still very happy with St Raphael's, we appreciate very much the care [person] receives" and "Everybody has been extremely nice, friendly and professional." One person who used the service wrote, "Thank you for being nice."

The service had received the "Investors in People" award. This is an international recognised accreditation which defines what it takes to lead, support and manage people well within an organisation.

The registered manager attended regular provider forums and conferences to keep themselves abreast of developments within the social care sector and cascaded relevant information to the staff team during meetings. This ensured that all staff were kept informed and up to date. This showed that the registered manager encouraged good communication and the sharing of information.

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 RA Regulations 2014 Person-centred care People were not consulted in relation to meals and there was no food planner displayed. Regulation 9(3)(i)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people using the service. Regulation 12(2)(i) Medicines were not managed safely. Regulation 12(2)(b)(g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality audits were not effective in highlighting concerns and mitigate risks to people. Regulation 17(2)(a)(b)