

Caretech Community Services (No.2) Limited

May Morning

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

We carried out this unannounced inspection on 17 November 2015. May Morning is a service for up to eight people with learning disabilities or autistic spectrum disorder who may also have some behaviours that other people could find challenging. The service was full at the time of inspection. People had their own bedrooms. The service was not accessible for people who needed to use a wheelchair or found stairs difficult. This service was last inspected on 13 September 2013 when we found the provider was meeting all the requirements of the legislation.

There was a registered manager in post. 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.

Staff had been trained in how to protect people, but in every day practice there was a culture within the service of not reporting some incidents which they viewed as minor. Staff understood the whistle blowing policy. They were confident they could raise any concerns with the

Summary of findings

registered manager or outside agencies if this was needed, but their view of incidents could be compromised by their assessment of the significance of some incidents.

Improvements were needed to the recruitment procedures for new staff to ensure these protected people from the appointment of staff who were unsuitable.

Medicines were managed safely by trained staff, but minor improvement was needed to ensure unused out of date medicines kept in the fridge were also disposed of appropriately.

A range of quality audits were in place to help the registered manager and provider monitor the service, but these were not sufficiently in depth or effective and failed to highlight the issues found at inspection, or provide the provider with the assurance that a safe standard of care was being maintained. People's relatives were routinely asked to comment about the service but were not informed about actions taken in response to their feedback.

Fire detection and alarm systems were maintained. Day staff knew how to protect people in the event of a fire as they had undertaken fire training and participated in fire drills. However, night staff were not routinely participating in fire drills to ensure they understood the actions to take to keep people safe.

Staff showed that they understood people's individual styles of communication, and how they made their needs known. Staff used communication aids such as pictorial prompt cards with some people to help them with making independent decisions and choices. However, there was an absence of visible accessible information for people to read about everyday routines and events.

People were happy and comfortable in the presence of staff. Relatives told us they were kept informed and had been consulted about their family members care and treatment plans.

Staff monitored people's health and wellbeing and supported them to access routine and

specialist health when this was needed. People ate a varied diet and were individually consulted about their personal food preferences to inform menu development.

People were given support to pursue their interests and hobbies. Each person had their own daily planner and this took account of their activity and interest preferences.

Risks were assessed, and risk reduction measures were developed and implemented to ensure people were kept safe; these were kept updated. Staff were provided with guidance to inform them about the actions to take in the event of emergency events so they knew who to contact and how to protect people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and had taken the appropriate steps to refer all the people living at the service who met the requirements for a DoLS authorisation. The service was meeting the requirements of the Deprivation of Liberty Safeguards.

There were enough staff to meet people's needs. Staff were provided with a wide range of essential and specialist training to help them understand and meet people's needs. They received support through regular staff meetings and had opportunities to discuss their performance through one to one meetings and annual appraisals of their work performance.

People lived in a clean, well maintained environment. Decoration and furnishings were maintained to a high standard. Equipment checks and servicing were regularly carried out to ensure the premises and equipment used was safe.

We have made three recommendations:

The provider should liaise with the Fire service to determine the expected number of fire drills night staff should attend in any one year in accordance with the Regulatory Reform (Fire Safety) Order 2005.

The registered manager should review staffing to enable staff to meet together with her without the presence of people who need support.

The provider reviews current practice around the availability of visible and accessible information to people.

Summary of findings

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

The service was not always safe

The recruitment procedure did not provide assurance that all required checks had been made of new staff. Medicines were not well managed. Staff did not routinely report abuse between people to the safeguarding team. Night staff did not participate in fire drills.

There were enough staff available to support people. The premises were well maintained and routine checks and tests of equipment were undertaken. Staff understood the action to take in emergencies to protect people from harm.

People were supported to take risks. Accidents and incidents were monitored and actions taken to minimise the risk of recurrence.

Requires improvement



Is the service effective?

The service was effective

Staff received induction to their role and essential and specialist training to enhance their skills and knowledge. They had opportunities to meet with their supervisor to discuss their performance, learning and development.

Staff understood how people communicated their needs and wishes. They consulted people about what they ate and provided them with a healthy varied diet. People's health and wellbeing was monitored.

People were supported to make decisions and choices and staff ensured they supported people to do this in line with the principles of the Mental Capacity Act 2005.

Good



Is the service caring?

The service was caring

Staff practices respected people's privacy and dignity. Staff showed kindness and patience and supported people in accordance with their assessed needs. People were provided with opportunities to spend time on their own or with staff to do things they wanted to do.

People were supported to maximise their potential and reach achievable goals towards greater independence. People were supported to reflect their own tastes and interests in the way they decorated their own rooms.

Relatives said staff consulted them and kept them informed, and they were made welcome by staff. Staff supported people to maintain links with their relatives, and arranged and supported visits to their family home for them.

Good



Is the service responsive?

The service was not always responsive

Requires improvement



Summary of findings

The investigation of complaints made by people did not consider if other agencies should be involved. There was no mechanism for recording how one to one funding was used and whether this was effective.

People were assessed prior to coming to live in the service to ensure their needs could be met. People and their relatives were involved and consulted about their care and treatment which was kept under review. Detailed care and support plans guided staff in ensuring care was delivered that was consistent with these.

People were provided with activity planners that took account of their interests and preferences. Relatives felt confident of approaching staff with any concerns.

Is the service well-led?

The service was not consistently well led

Systems to assess and monitor service quality and feedback from people, their relatives or other stakeholders were not implemented effectively. There was a lack of visible and accessible information for people. The presence of people at staff meetings prevented team discussion about people's needs. The registered manager received group supervision but this was not recorded.

There was a registered manager who staff, people and their relatives found approachable and supportive. Staff said they felt listened to, and able to express their views at staff meetings.

Staff practice was informed by policies and procedures that were kept updated.

Requires improvement



May Morning

Detailed findings

Background to this inspection

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

This inspection took place on the 17 November 2015 and was unannounced. The inspection team consisted of one inspector.

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 also looked at all the other information we held about the service, including previous reports, complaints and notifications. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We met all the people that lived in the service during the course of the inspection. Most people were unable to speak with us directly about their views of the service, so we used a number of different methods to help us understand their experiences including the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We received feedback from three relatives who spoke positively about the service and raised no issues of concern. We spoke with three care staff, the deputy manager, and the registered manager. Prior to and following the inspection we received feedback from five health and social care professionals who also raised no issues of concern.

We looked at three people's care and support plans, risk assessments, activity planners, and health record. We also looked at medicine records, and menus, and operational records for the service including: staff recruitment, training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Is the service safe?

Our findings

Relatives and social care professionals spoke positively about the service and said it was a safe environment. They commented about the upgrading of the premises and the high standard of accommodation people now enjoyed. A social care professional told us “The home itself has been updated and she (the person they visit) was fully involved in every aspect”. A relative told us “she has such a lovely big room now” and “I can’t fault the service”.

Improvements were needed to ensure the provider operated safe recruitment procedures. The provider was not operating safe recruitment practices. All three staff recruitment records lacked confirmation that health declarations had been obtained. One file lacked a Disclosure and Barring Service (DBS) criminal record check. Two files did not confirm that gaps in employment histories had been checked along with verification of reasons for leaving previous care roles. These processes help employers make safer recruitment decisions and this helps prevent unsuitable people from working with people who use care and support services.

The failure to ensure that all required recruitment information was in place for individual staff is a breach of Regulation 19 (3) (a) and schedule 3 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from harm. There had been incidents of abuse between people in the service such as kicks, punches and pinches. Although staff had received regular training in protecting people from abuse and told us they felt confident about raising concerns with the provider or outside agencies if this was necessary, these incidents had not been reported to the local authority safeguarding team. This placed people at risk of harm as these incidents were on going, and there was no involvement from outside professionals to determine the steps needed to keep people safe from harm.

The failure to ensure that safeguarding procedures are followed and all physical and verbal assaults and allegations of people in the service were reported to the relevant safeguarding authority is a breach of Regulation 13 (3) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. Although medicine storage was clean and tidy, creams in people’s medicine cabinets were not stored in a separate container to avoid seepage into oral medicines which could spoil their effectiveness. We also found two expired creams in the drugs fridge that staff said were no longer used but had not been disposed of; there was a risk these could be reused by staff if they were still available.

There was a failure to ensure that prescribed creams were stored appropriately and that medicine audits and stock checks ensured that expired creams were returned to the pharmacy or disposed of. This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were unable to administer their own medicines and this was made clear in their care records. A drugs fridge was in place for medicines that required storage in cool temperatures, staff also monitored temperatures of individual medicine cabinets. Only trained staff administered medicines and their competency to do so safely was assessed every six months. Medicine Administration Records (MAR) charts were completed properly with appropriate use of codes when medicines were not administered. A clear protocol was in place for staff when administering medicines that were not for everyday use to make clear in what circumstances these could be used. A photograph of each person was provided with each individual medicine record to ensure the right medicine was administered to the right person. A returns book was used to return unwanted medicines to the pharmacy.

Fire alarm systems were regularly maintained. Internal checks and tests of fire safety systems and equipment were made regularly and recorded. Staff knew how to protect people in the event of fire as they had undertaken fire training and took part in practice fire drills. However night staff had not routinely participated in fire drills and had not attended any since January 2015. This is an area that requires improvement.

Personal evacuation plans took account of people’s individual needs in the event of an emergency evacuation and helped ensure this was undertaken safely. Staff understood their role in an emergency and clear guidance was available to inform them of the actions they needed to

Is the service safe?

take in the event of emergency situations; including a business continuity plan, for responding to events that could impact on the running of the service and making contact with the right people and agencies.

The service had recently been refurbished and the premises, décor and furnishings were maintained to a high standard. They provided people with a clean, tidy and comfortable home. The registered manager and staff confirmed that repairs were dealt with quickly, and a programme of further works to enhance the garden area was planned. Equipment checks and servicing were regularly carried out to ensure this was safe and in good working order.

Staff told us and rotas showed there were sufficient staff on shift at all times during the day to meet the needs of people. Staff worked a staggered rota to respond to when people got up and needed support, for example during inspection routines were relaxed, people were given time to get up and get dressed, they had breakfast at times suited to their routine, and went out when they were ready to, and if they wanted to. By 11:00 am there were six staff in place until 5pm, during the week the presence of registered manager added to this total. As people returned from their activities the numbers of staff gradually reduced with four staff on duty from 5pm onwards, this reduced further to three by 9pm and at 9.30 pm two waking night staff take over.

At times of staff shortage, to maintain continuity for people, staffing cover was provided from within the existing staff team, or from a preferred agency that supplied staff familiar with the needs of the people in the service and their routines. There was a lack of additional staffing to cover staff meetings and provide people with occupation and

stimulation while their usual staff were occupied. This meant that people sat in on meetings which impacted on what could and could not be discussed. This is an area for improvement.

Each person had their own set of individualised risk assessments; these took account of each person's personal awareness and understanding of danger and risk. Risk reduction measures were implemented to reduce the level of risk so that people were protected from harm in their daily routines and activities. For example, one person was at risk from getting out of the garden gate, although they did not go out without staff supervision, a chain had been installed on the exit gate as a secondary protection to prevent access outside of the garden without staff supervision. Risk assessments were kept updated and reviewed on a regular basis.

There were a low level of accidents and incidents. These were monitored by the provider and the registered manager, and discussed with staff if any changes in support were needed, to prevent similar occurrences in the future. A range of general risk assessments had been developed of risks from the environment and activities undertaken in the service that could impact on all the people living there; these were kept under review by the registered manager, to ensure that the environment remained safe for people.

We recommend:

The provider should liaise with the Fire service to determine the expected number of fire drills night staff should attend in any one year in accordance with the Regulatory Reform (Fire Safety) Order 2005.

The registered manager should review staffing to enable staff to meet together with her without the presence of people who need support.

Is the service effective?

Our findings

Social care professionals commented on the good work undertaken by the staff team in managing previous behaviours that could be challenging they said: “I have always found a consistent caring approach with clients who have emotional and physical behaviors that may challenge”. Another said “She has progressed very well at May Morning considering her needs/behaviour when she moved there.” Relatives and social care professionals told us that the registered manager and staff were particularly good at communicating health issues people may have, and been supportive and caring when health interventions had been needed for some people.

Staff were provided with the right support knowledge and skills to undertake their job role. Newly appointed staff said they had been made to feel welcome. Induction prepared new staff by giving them an understanding of the routines within the service and the needs of the people being supported, so they understood how to protect them from harm. They shadowed more experienced staff and completed a four day class room based induction programme that provided them with some of the essential skills training that they were required to do, including conflict management resolution and restraint reduction techniques.

All new staff completed a probationary period and met regularly with the registered manager, where their progress and competence was assessed and discussed with them. Agency staff prior to starting a shift were required to complete a confidentiality statement and time was spent with them going through a task list so they knew what they were there to do.

For established members of the staff team there was a mixed programme of class room based and e-learning refresher courses in a variety of topics, such as safeguarding, food hygiene and health and safety. Specialist training relevant to the needs of the people in the service was also provided to all staff, for example Autism, and awareness of epilepsy. Seven staff had achieved nationally recognised vocational care qualifications at Level 2 or higher.

Staff told us that they were supported through individual one to one monthly meetings with their supervisor. These meetings provided opportunities for staff to discuss their

performance, development and training needs. Staff in post for more than one year received an annual appraisal and the registered manager had scheduled these in for this year.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. A DoLS checklist was completed for each person; where this highlighted the person met the requirements for a DoLS authorisation the registered manager had referred people accordingly. Six people had already been referred for DoLS authorisations and to date two had been authorised. On a day to day basis staff supported people when making everyday decisions about what they wore, where they ate, what they ate, what they wanted to do, and mental capacity assessments were in place to support the need for staff to help people make some of these decisions.

Where people lacked the capacity to make some more important decisions for themselves around their care and treatment the service was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person’s best interests, and by people who knew them well. The registered manager understood that for one person an advocate would need to be sourced to act on their behalf should a complex decision about their future care or treatment need to be made.

People could on occasion express behaviour that could be challenging to staff or other people. All staff were trained in conflict management and resolution and also restraint techniques. Each person had detailed guidance for staff that explained the behaviour they could show, possible causes for this, and how to manage the behaviour using a range of interventions that the person was signed up for including as a last resort physical restraint. Staff responses were guided by clear protocols and information specific to each person, as to how best to de-escalate and manage incidents of behaviour.

The registered manager and provider representatives monitored incidents of behaviour and

looked for patterns and causes for the behaviour. There had been a significant drop in the number of incidents people were experiencing and this gave the registered manager and staff confidence that the support they provided to people at times of high anxiety had been effective in reducing incidents of aggression.

Is the service effective?

People or others who knew them well were consulted about their food preferences prior to their admission to the service, and these were taken account of in the development of menus that ran over a four week cycle. People were given choices about what they ate and staff encouraged them to eat a healthy balanced diet. Staff recorded people's food intake to ensure this was at a satisfactory level that did not highlight a risk of poor nutrition. Some people also had fluid charts in place to monitor how much they were drinking each day. People's weights were regularly recorded and any significant changes reported to the registered manager.

People were supported by staff to maintain their health and wellbeing. Routine health checks with doctors, dentist and opticians were arranged, and where necessary referrals were made to other health professionals, for example psychiatric assessment. A record was kept of all health

appointments and contacts; each person had a file entitled "My keeping healthy – things you must know about me". This gave details of the people who needed to be involved in making decisions with the person about their health, and how the person responded when they were unwell so that staff could identify that the person was not well.

A health action plan was in place for each person with a checklist to ensure all aspects of their healthcare needs were kept under review and medication reviews undertaken. Relatives told us that they were kept informed of any issues regarding the health and wellbeing of their family member and that the service followed up any medical concerns quickly. A social care professional told us that the registered manager had been proactive in liaising with a GP about a health issue for one person and that this would possibly lead to a best interest meeting to agree to a health intervention.

Is the service caring?

Our findings

People were comfortable with staff and were happy to be around them and be involved in activities with them. Staff were friendly and kind in their support and responses to people. The attitude of staff was respectful and they showed that they understood people's individual characters and needs. A social care professional said that the person they visited had shown them their bedroom and it was clean tidy and decorated with the persons possessions. Another said about the person they visited "She is supported very well and has progressed in all areas". A third professional said "I know when I visit her she always is appropriately dressed and appears content and happy".

Relatives said they found staff helpful and supportive in arranging visits home for their relative particularly in providing the transport to and from the service for those relatives who could not provide this. A relative told us that "This is the best place he's ever been" and commented "he associates himself more with the staff than with the other people living there". Relatives commented that their family members were always happy to return back to the service after home visits. "He is always happy to return there" and "She is always pleased to go back".

Staff were adept at understanding people's different styles of communication, we were informed that most people could read text but had different reading abilities. One person who was non-verbal used pictorial prompt cards with staff to make known their needs and preferences.

Staff protected people's dignity and privacy by providing personal care support discreetly, respecting confidentiality and speaking about people's needs with other staff in privacy. The storage of people's individual medicines in cabinets in their bedrooms had improved privacy and dignity for them when their medicine was administered. Staff were mindful of the presence of people in staff meetings and withheld discussing confidential matters in the presence of people.

Relatives and social care professional told us that they thought communication from the registered manager and staff in general was good. One relative told us that staff

from the service kept them informed and sometimes telephoned them for information about their son that helped them build a profile of his likes, dislikes and behaviours.

There was a relaxed atmosphere in the service. We observed examples of gentle patient and supportive interactions between staff and the people they were supporting. Staff supported people to make choices and decisions for themselves in their everyday lives about how they spent their time, when they went to bed, what they wore, or did, where they ate and what they ate. Staff respected people's choices. Staff protected people's dignity and privacy by providing personal care support discreetly, respecting confidentiality and speaking about people's needs with other staff in privacy.

People's potential for developing skills was assessed. Goals for achieving independence in some of their care and treatment routines were established; people worked towards these at a pace to suit themselves. The majority of people had allocated one to one hours funded by their placing authority, one relative said their family member benefitted greatly from this arrangement and just having one to one time with a staff member, they felt it vital that this continued to happen.

When at home people moved freely around the service with the exception of other people's bedrooms. People often popped into the registered manager and deputy's offices to see what was going on and staff said one or two people liked to come down at night for a hot drink or one person came down to spend time on the office computer accessing the internet with staff support.

People were able to choose where they spent their time, for example, sitting in on a staff meeting.

They had their own bedrooms and some people liked to spend time there. Bedrooms had been individually personalised with people's possessions reflecting their interests and tastes. The new décor had been left neutral so that people could add colour through their possessions and some people had been supported to cover the walls of their bedrooms with art works, pictures and shelves.

People's care plans contained information about the important people in their lives and important events they

Is the service caring?

needed to be reminded about. People were supported to maintain relationships with the people who were important to them, and were supported by staff to make regular contacts or visits home.

Is the service responsive?

Our findings

A social care professional told us that they thought the service was meeting the needs of the person they were responsible for; another said that the staff “excelled at communication and joint working with parents”. A third professional said “They support her to have a voice and her yearly goals she sets are worked on with her thoroughly”, “Her support plans and risk assessments are clear and she is fully involved with reviewing them.” Relatives told us that they were invited to and consulted about reviews of care; they felt they could contribute to these and felt listened to.

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the new person’s needs. The assessment was undertaken over a period of time and at a pace to suit the person concerned. The provider requested reports from the previous care provider and representatives; they made visits to meet the person in their current placement. These processes enabled information to be gathered about the person to inform the overall assessment. Prospective residents were invited for trial visits and stays. Following these visits the views of staff and observations of how other people in the service reacted to the new person were taken into account and considered in the final decision to admit.

Following initial assessment and admission people’s everyday care and support was designed around their specific individual assessed needs. This included an understanding of their background history, interests, preferences around day and night routines, communication, personal care, social activities and interaction with others and the important people in their lives. This information provided staff with a fuller understanding of the person as a whole and guided them in delivering support consistent with what the person needed and wanted. There was also recognition of what people could do for themselves and achievable goals were set to help them to develop and enhance their skills, at a pace in keeping with their abilities. Some people had additional funding for staff to spend one to one time with them; there was no mechanism for recording this or whether it was being used effectively. This is an area which requires improvement.

A social care professional commented positively on the quality of plans of support and that people were given opportunities to reach their potential for a “fulfilled and

happy independent life”. Changes in people’s care and treatment were discussed with their relatives and representatives before these were put into place. People and their relatives were included in the regular assessments and reviews of their individual needs.

Relatives thought that people were provided with enough activities and said that sometimes people chose not to go out despite what was on offer. Weekly activity planners were in place for each person; these had been developed from knowledge gathered from people and their relatives about what people were interested in and liked to do. This was adjusted if people lost interest in particular activities and alternatives were offered. Planners showed that people were supported into the community sometimes every day or several times per week dependent on their preferences, and this was supported in daily reports completed by staff for each person, that summarised how people had been, what they had eaten, and what they had done each day. People were also given opportunities to meet with people from other services at evening discos where they could expand their social circle and make friends if they wished.

There was a complaints procedure and people had a copy of this in their care record but an accessible copy of this was not displayed to remind people how to complain or express their concerns, and this is an area for improvement. There was a complaints record for recording of formal complaints received, the PIR informed us that there had been one complaint received from a person in the last 12 months and this was recorded in the log as having been investigated, that a meeting was held with the complainant and the matter resolved to their satisfaction. As the complaint related to staff attitudes, we consider that this matter should have initially been referred to the safeguarding team to assess but was not; we discussed this with the manager at the time of inspection and this is an area for improvement.

Relatives however, said they felt confident of raising concerns if they had any, and always found the registered manager and staff approachable. Staff understood how people used sign, body language or their general mood, behaviour and demeanour to show that they were unhappy or sad, and said that they would always look for

Is the service responsive?

the causes of this. They had time each month to spend with people on an individual basis to ask them about their needs and support and whether they were concerned about anything.

Is the service well-led?

Our findings

Relatives, social care professionals and staff spoke positively about the service and the way it was managed. Staff told us “I find the locality manager very approachable and the registered manager is “brilliant “She never makes you feel you’re wasting her time”, another said “The registered manager and deputy work well together”. Social care professionals commented: “May Morning has always offered a high standard of care which has always appeared to be well led and person centered”, another said “I feel this is a very well managed environment”. Relatives told us that the registered manager and staff maintained good links with them and kept them informed, another said “they have been very accommodating and helpful in keeping us informed and making home visits happen”. Relatives told us that they were sent surveys from time to time that asked for their views about the service, but did not know what happened with this information; one person said “I send it back but I never hear anything about it”.

A range of audits were undertaken each week, month and also quarterly in house. Individual staff had delegated responsibilities to conduct one or more of these audits. The registered manager and deputy manager were responsible for checking that these were being completed. Audits included checks of medicines, vehicle checks, health and safety checks, finance checks, cleaning and catering checks, and care plan record checks. The registered manager also completed a monthly report for the locality manager that checked all aspects of the service to assure the locality manager that tasks allotted to staff were being completed. Actions from individual audits were added to an overall service development plan with expected end dates for actions to be completed.

The locality manager checked progress towards these actions during supervisions, and regular compliance checks she undertook. The provider also ensured that a Health and safety audit and assessment was undertaken annually by an external agency. An internal compliance and regulations inspection team visited six monthly to assess service quality and compliance. A six monthly internal financial audit was also undertaken. Actions from these audits were added to the service improvement plan and monitored for completion. Despite the number and

range of audits at different levels of the organisation these were not effective in identifying the shortfalls highlighted by this inspection and this could pose a risk of people not receiving the support they need.

People had opportunities to feedback their views about the service at their monthly meetings relatives told us that they were asked for their views and felt listened to but there was no evidence of how information gathered from surveys of people, their relatives, or other was used. The service improvement plans did not make reference to feedback from people or other stakeholders and how this was informing service development.

Some people’s behaviour made it difficult to keep paper documentation on notice boards for other people to see. As a result notice boards had been removed; this had left people without accessible information to make decisions in their daily lives for example, about forthcoming events, how they could make a complaint, or obtain advocacy, who was on duty and even what the day and date were and what the weather was like. No action had been taken to resolve this issue so that people were not disadvantaged. We spoke with the registered manager about possible solutions but this is an area for improvement.

There was a failure to ensure that systems to assess and monitor service quality and feedback from people, their relatives or other stakeholders were being implemented effectively. This is a breach of Regulation 17 (2) (a) (e) of the Health and social Care Act 2008 (Regulated Activities) 2014.

The registered manager received one to one supervision from the locality manager but these were less frequent than group supervisions with other registered managers. Group supervisions were held as part of registered manager meetings, but no formal record was made of the supervision element of these meetings; registered managers were therefore unable to refer to the matters discussed within these group supervisions and the agreed actions, this is an area for improvement.

Senior staff met monthly with the registered manager but these meetings were not recorded and this is an area for improvement. Staff said that they felt communication was good and they worked well together as team members. Regular staff meetings were held and staff said they found these safe places to raise issues, and that they felt listened to. People were welcome to sit in on staff meetings but this

Is the service well-led?

prevented staff from discussing important matters as a team that related to the care and support of individual people. We discussed this with the registered manager at inspection and this is an area for improvement.

The registered manager had joined the organisation in the last five years; she managed this and an adjoining service that was currently empty whilst refurbishment was completed. Staff said she was a good manager and they felt supported by her and the deputy manager; staff said both managers were readily available, and easy to talk to. Staff said they felt listened to and felt confident about expressing their views. Staff told us that they found the locality manager approachable and that she made herself a visible presence to people and staff when she visited.

In the PIR the registered manager stated that staff at the service had good working relationships with care managers and other professionals, and social care professionals told us that staff kept them updated and communication from

them was very informative. The service also had a close working relationship with the local community learning disability team and was registered with the Care Homes Learning Network, Skills for care, and the Social Care Commitment.

The language used within records reflected a positive and professional attitude towards the people supported. Staff had access to policies and procedures, which were contained within a folder and was held in the service. Policies and procedures were reviewed regularly by the organisation to ensure any changes in practice, or guidance is taken account of, staff were made aware of policy updates and reminded to read them.

We recommend:

The provider should review current arrangements around the provision and availability of visible and accessible information for people.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

There was a failure to ensure that prescribed creams were stored appropriately or that medicine audits and stock checks ensured that expired creams were returned to the pharmacy or disposed of Regulation 12 (2) (g).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

There was a failure to ensure that safeguarding procedures were followed and all physical and verbal assaults and allegations of people in the service were reported to the relevant safeguarding authority Regulation 13.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

There was a failure to ensure that some records and systems to assess and monitor service quality and feedback from people, their relatives or other stakeholders were being implemented effectively. Regulation 17.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

There was a failure to ensure that all required recruitment information was in place for individual staff Regulation 19.