

Mid-Norfolk Mencap

Merle Boddy House

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 

Summary of findings

Overall summary

The inspection took place on 23 July 2018 and was unannounced. The last inspection to this service was 21 July 2017. The service was rated 'requires improvement' in three key questions we inspect against: Safe, Effective and Well led. There were two breaches of regulation; one for clinical oversight and governance and the other regarding the recruitment of new staff. Following this inspection, the provider sent us an action plan stating how they had addressed our concerns. At the inspection on the 23 July 2018 we found the service had significantly improved but there was still a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We found concerns about the premises and unassessed risk. Care records were poorly organised in terms of accessibility to help ensure people received consistently safe care. This meant we had concerns about the oversight and clinical governance as these concerns had not been identified by the service.

Merle Boddy House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can accommodate up to ten people who have a learning disability. Accommodation was spacious and provided easy access to Norwich. Everyone had their own bedroom and generous communal space.

The care service had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

There was a registered manager in place 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.

In summary we found, since the last inspection to this service the manager had become registered having only been in post a couple of weeks at the last inspection.

They had made efforts to change the environment and this was generally suited to people's assessed needs. However, we identified several potential risks posed both by the environment but also from the lack of assessment and planning around individual risks.

We found records were not sufficiently robust in illustrating changes to people's needs or how these were being addressed. Staff were familiar with people's needs so this lessened the risk of people not getting their needs met. However, there was still a risk in staff not being fully aware of changes to the persons plan of care or treatment because this was not accurately reflected in the records.

The above gave us concerns about the oversight of the service and how robust the quality assurance systems were in identifying concerns.

We found them to be open, friendly and knowledgeable. They told us the ethos of the service had been poor and people did not have sufficient opportunity to develop their skills and confidence through increased participation in the community. They had worked hard to change the culture of the service and help each person develop and grow. This had meant changing the staffing culture through regular support, challenge and providing the necessary training to develop staff. In addition, they had asked for support from the trustees to change the way they worked and to have a more hands on approach.

There were systems in place to help ensure the environment and equipment on the premises was in good order and staff were trained to act in an emergency, including fire evacuation.

Staff understood what constituted abuse and how to protect people from potential harm. Staff receiving training and updates for adult protection. Incidents/accidents and safeguarding concerns were documented and showed lessons learnt.

The service had an adequate staff recruitment programme aimed at ensuring only staff who were suitable for the role were employed and of good character.

There were systems in place to help ensure sufficient numbers of staff were employed to meet people's assessed needs and facilitate their choices.

Medicines were administered as intended by staff qualified to do so.

The service was hygienically clean and infection kept to a minimum.

Staff received the necessary support, guidance and training for their job role. This helped them to meet the needs of people they were supporting.

People were supported to eat and drink sufficient to their needs. Staff monitored people's health and encouraged and supported people to see a GP or other health care professional as required. However, we found records to support this were not always adequate.

People were supported in their decision making and valid consent was sought before care and treatment was given. This was being reviewed in line with existing applications for the Deprivation of liberties safeguards.

People had adequate activity around their individual needs and choices. We could not see how people were always supported to achieve their goals and what they had achieved.

There was an established complaints procedure and the service considered feedback from people and families and adapted the service accordingly.

End of life planning was not in place but staff were sensitive to the issue and knew how they would support people to ensure they received the care they needed.

Staff were kind and caring and respected people they supported. They upheld their dignity and privacy and supported them with their daily routines.

Staff encouraged people to retain their independence and to learn new skills. People were encouraged to make their own decisions and be involved in decision making about the service they received.

The manager was approachable and knowledgeable. They had set about to change the service to help ensure it reflected the needs and wishes of people it was supporting. They had provided leadership and support to staff. They had created a more open person-centred culture. They were addressing some of the issues created by the environment to help ensure it reflected the needs of people using the service.

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 mostly safe.

The service had several risks identified on the day both in relation to the immediate environment and risks associated with people's care. These had not been identified by the service.

There were sufficient staff to meet the needs of people using the service.

Risks were mostly assessed and mitigated. The environment was mostly fit for purpose and clean.

Medicines were administered as intended by staff qualified to do so.

Staff understood what constituted abuse and how to protect people from it.

Requires Improvement ●

Is the service effective?

The service was effective.

Staff kept their knowledge and practices up to date. They received a good induction and regular training and support for their role.

People were supported to eat and drink sufficient for their needs and this was monitored by staff. People were supported to have their needs met in regard to their health care needs and long-term conditions like epilepsy. This was not always adequately supported by care records.

The environment was spacious, well maintained and mostly fit for purpose.

People had choices and decided about their care and treatment. Whilst staff recognised the importance of choice they also understood people might need support to make more complex decisions and understood how to support people lawfully.

Good ●

Is the service caring?

Good ●

The service was caring.

Staff knew people's needs well and responded to them in a timely way.

Staffs interactions were appropriate and they supported people's emotional well-being and upheld their dignity and privacy.

Staff encouraged people to retain their independence and do what they could for themselves.

People were involved in their day to day care and wider decisions about their environment and how they wished to spend their time

Is the service responsive?

The service was not fully responsive.

We found staff had sufficient knowledge of people's needs and their likes, dislikes and routines. Care records did not always give a complete picture of the persons assessed needs and gaps in records exposed people to unnecessary risk of receiving the wrong care or treatment.

People had opportunities to go out and pursue things that interested them.

The service supported people for as long as it was appropriate to do so and this included end of life. Care records did not reflect people's preferences regarding end of life care.

Requires Improvement ●

Is the service well-led?

The service was not always well led. A lot had been achieved by the current registered manager and the service was moving in the right direction.

There were systems in place to identify the quality of the service and to identify any improvements necessary in terms of health and safety, the environment and the care. We identified some gaps in this process so could not be assured the systems in place to measure the quality and safety of the service were fully effective.

The service was run in the interest of people using it and care and support was provided by motivated, cheerful staff.

Requires Improvement ●

Merle Boddy House

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 took place on 23 July 2018 and was unannounced. The inspection was undertaken by two inspectors, one of whom was within their initial induction.

Prior to the inspection we reviewed information already held about the service including the previous inspection report. We also looked at notifications which are important events the service are required to tell us. We did not receive an up to date provider information return which tells us how the service is being managed against the regulations and how care is being provided.

As part of the inspection we carried out observation of care interactions between people using the service and staff. This was important as not everyone using the service could tell us about their experiences. We spoke with four care staff and five people using the service. We also spoke with the registered manager. We looked at four care records, staff records and other records relating to the management and oversight of the service.

Is the service safe?

Our findings

At our last inspection to this service on 21 July 2017 we found a breach in regulation with regards to staff recruitment which was not sufficiently robust. At our inspection on the 23 July 2018 we found staff recruitment satisfactory. However, we found other concerns which had the potential to affect the safety of people using the service.

The registered manager said staff recruitment used to be done remotely. This had improved and was now carried out in the home and interview questions were centred around the needs of people living there. Of the records we looked at we found clear evidence of adequate recruitment. There was a record of the interview and any concerns such as gaps in employment history were explored. The interview showed how the candidate had demonstrated their suitability for the post including their initial interactions with people using the service. Pre-employment checks included references, a completed application form, proof of identify and address, as well as any qualifications relevant to care. They also had a disclosure and barring check (DBS) which established if the staff member had committed any offence which might prevent them working in care.

Staff knew people well which meant people received continuity of care. However, we found people's records were not easy to navigate and had concerns that temporary members of staff who were less familiar with people's needs might not have access to the right information. Each person had several files. One gave a brief overview of the person's needs and included information such as allergies, any specific health information and the persons likes, dislikes and preferred routines. The other record had care plans, risk assessments and other information such as appointments. A lot of the records had been archived and there was no cross referencing so we were not always able to draw conclusions as to how a person's needs should be met.

A further file included recent risks assessment following incidents or a change in a person's needs. They were left in a file until staff had read and signed them before being moved into the persons main file. We saw a recent incident form which stated the person's risk assessment had been updated. However, this could not initially be found in their file or in the separate newly revised risk assessments. The registered manager did locate it eventually but it meant staff did not have access to important information about the person's care. We reviewed a risk assessment and epilepsy care plan for a person. The plan was detailed and had been collectively drawn up with a range of professionals and was robust. However, a change in the person's needs had resulted in a review of their medication and the consultant had withdrawn one of their medicines. The epilepsy management plan had not been updated which meant staff could mistakenly administer the wrong medication. This was unlikely as staff knew people well. However, there was still a risk, particularly if the person went into hospital, that accurate information was not immediately available.

Health records did not always show how risks to people's health had been properly mitigated. There was no separate health care plan or continuous health care record. One person had been seen by the dentist who said they had a build-up of plaque on their teeth. As a result, they had been prescribed some mouth wash. However, there was no oral hygiene assessment in place or care plan addressing the support they needed in

this area of care. Poor oral hygiene could lead to further avoidable health complications. Another person's records suggested that their weight should be monitored regularly. However, there was no evidence in their record that this was happening. For another person evidence of referrals to the speech and language team did not show what advice or change of care if any this person needed.

In discussion with the registered manager, they agreed to put into place health action plans and oral hygiene assessments and care plans where a level of risk was indicated.

Most individual's risks were documented and mitigated as far as reasonably possible such as risk of trips, slips and falls and risks associated with everyday activities such as accessing the kitchen and cooking. We noted a person with epilepsy with unsteady movement was able to access the kitchen and make drinks independently but was given appropriate staff support to do so. Several people had severe and frequent epilepsy. One person wore a head guard for their safety, another had a night monitoring alarm to alert staff to any seizure activity. The person had consented to have this in place.

We had minor concerns about the environment but were confident these were being addressed. The service was sufficiently clean and the communal and individual space suitable for people's assessed needs. There was equipment in place to assist people, such as a grab rail and a ramp to the garden. However, we found the toilet on the ground floor required refurbishment. There were cracked tiles and a sharp bit of metal coming out just above the sink which could cause injury to people, given that some people were unsteady on their feet and prone to epilepsy. We found the pipe work under the sink not covered and radiators not covered. The surface temperature was cool as radiators were not on but we could not be assured this was always the case. This meant there could be a risk of burns on contact. The service was uncomfortably hot and we saw staff suffering given that they were working all day. There were no fans or air conditioning in the service. Windows upstairs could open fully and were not restricted which could pose a risk to people living there. These risks had not been identified so we were unable to assess the likely impact these may have on people using the service. However, the registered manager said they were aware of people's needs and could move people to ground floor accommodation if this was more appropriate.

Risks to the environment were reduced by the levels of staff supervision. There were appropriate checks in place to help ensure equipment used was both safe and properly maintained. We looked at a sample of maintenance records and procedures in the event of a fire. People had individual risk assessments which stated what assistance they might need in an event of a fire. There were regular fire drills and checks on alarms and other equipment used to fight fire. Cleaning materials were locked away and there were data hazard sheets in place so staff knew what chemicals they were handling and what actions they should take if they were exposed to unnecessary risks. Audits included testing water temperatures and there were thermostatically controlled valves fitted which should prevent water-pipework becoming too hot. We saw the portable appliance testing record, electrical installation record, the legionnaires report and asbestos report. These were all satisfactory.

Incidents/accidents and notifications were documented and had been referred to other agencies when appropriate to do so. Trustees had oversight of this. We noted altercations between people were documented, any injury was recorded on notes/body maps. Several minor medication errors were recorded and had been reported and dealt with appropriately through the relevant health care professional and actions taken with staff to help support and improve their practice whilst they refrained from giving medication.

Staffing levels were appropriate for people's assessed needs. The staffing rotas enabled people to have the support they needed both around personal care needs and social care needs. At the time of our inspection

there were eight people using the service and four staff on duty. One person had been identified as needing one to one support all the time to ensure risks associated with their care were appropriately managed. Staffing levels at night took this in to account and there were three waking night staff at any one time. Staffing levels fluctuated during the day according to what people were doing and some went out to a community hub and accessed a range of services.

Staffing rotas were prepared four weeks in advance and there was a full complement of staff including relief staff who worked between this residential service and a community outreach service. Agency staff were also used to cover holidays and sickness. We spoke with an agency staff on duty and they told us they were there regularly, knew people well and enjoyed coming there. The registered manager had created a new post of shift leader and had two senior staff who supported and directed care staff. The registered manager worked flexibly including weekends, giving them a clear overview of the service at different times of the day.

The risks of abuse were reduced as far as reasonably possible because staff had a sufficient knowledge of what constituted abuse and what actions they should take to safeguard people. Staff spoken with were confident about reporting it and taking the right actions. They received regular and updated training. There was information in the office giving contact details for the Local Authority safeguarding team and guidance about what and when to report concerns.

One staff member spoke about getting to know people well and recognising changes in their behaviour, however subtle, which could be a potential indicator of something wrong. They spoke of occasional aggression between people using the service and how staff were trained to de-escalate any emerging situations. They also recognised the importance of recording, reporting and acting in people's interest to safeguard them from harm. They referred to the organisations' whistle blowing policy and other agencies such as CQC who they would notify.

There were adequate arrangements in place for people's money and its safe keeping. This included clear financial accounting procedures and audits to ensure monies were accounted for.

There were systems in place to help ensure people received their medicines safely and as intended. All staff were trained to administer medicines. Training was provided at staff's initial induction and refreshed annually. Competency assessments were carried out at least three times to ensure staff had understood their medicines training and could give medicines safely.

There were clear procedures in place to ensure medicines were safely ordered and checked in so they were in place when people needed them. They were locked away and temperatures kept ensuring medicines remained sufficiently intact and effective. Stock was rotated and staff signed and dated any creams or other medicines such as eye drops when opened. These were discarded according to the manufacturers instruction. There were clear policies and procedures including return medication and what to do in the event of a medication error.

There was information about each person's needs in relation to medicines including what they had been administered and any special instruction with regards to administering medicines.

Is the service effective?

Our findings

At our last inspection to this service on 21 July 2017 we found this key question required improvement. At our inspection on the 23 July 2018 we rated this key question as 'good'. Staff development and support had been effectively established since the registered manager had come into post last year. Staff on induction initially did three shadow shifts where they were supernumerary. This was kept under review to monitor the staff's performance and to ensure they felt confident before expecting them to work on their own. The three days could be extended to give the staff member as long as they needed.

We noted there was no recorded induction for agency staff although they did not work unsupervised with individual people. The registered manager told us they had been employed at the service for a long time and would now ensure all new staff had a recorded induction.

Staff's development was ongoing with at least 80% of staff with an enhanced qualification in care. The registered manager had done an enhanced NVQ to level 5 and senior staff were doing more advanced qualifications. The service regularly linked with 'skills for care' to help them develop best practice and keep up to date with updated guidance and any key legislative practice.

We saw staff had ongoing support through regular planned one to one supervisions and observations of practice. Supervisions were face to face and enabled staff to discuss with their manager how things were going and if they needed any additional support or training. The registered manager said they followed disciplinary procedures when necessary and did observations of practice to ensure staff were following policies and delivering care according to people's care plans. The registered manager said they took the opportunity to note any positive as well as negative practice which was recorded as part of staff's ongoing supervision.

Staff records confirmed they completed regular training which the organisation deemed mandatory, as well as training around the specific needs of people they were supporting. Staff records evidenced that regular supervision took place and there was an induction checklist and evidence of shadow shifts. This summarised progress made against the job description and desired skill set. The registered manager confirmed they did not currently offer a staff appraisal but were introducing a more in depth annual review of staff's progress, developmental and training needs.

People were supported with their hydration and nutritional needs. Staff confirmed that they knew people's dietary needs and any likes and dislikes. People were involved in selecting meals they would like and where able, were involved in the cooking process. Most of the shopping was purchased online for the week but on a Friday people could shop with staff for the weekend. We saw people were consulted about what they would like to eat and asked for their preferences.

Care plans told us about people's dietary needs and preferences but did not include people's weights routinely. The only exception to this is where staff had concerns about someone in terms of the stability of their weight or where they had been ill and might have a reduced appetite.

People's health care needs were monitored and met by staff and other health care professionals. A few people had severe and persistent epilepsy. The staff team had been supported and trained by the epilepsy specialist nurse to help ensure they could monitor and manage people's seizure activity safely.

Staff confirmed they supported people to access other healthcare services such as community dentists, opticians and their local GP practice. We saw the service did seek advice from other health care professionals and acted on advice. For example, one person aspirated on food although being supervised at the time by staff. Staff immediately referred them to the speech and language team to ascertain any risk/actions they should take.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. The service had made applications to the local authority in some instances to deprive people of their liberty because not everyone could fully consent to their care and treatment and it would be unsafe for some people to leave as they wanted. The service was actively chasing the local authority regarding these applications. People had been assessed as having capacity to make simple day to day decisions but staff felt people would need more assistance to understand complex decisions and said initially they would support people by providing adequate levels of information. Staff recognised best interest decisions might be necessary and recognised what the processes would be to ensure this happened properly and who would need to be involved.

We noted no restrictions for people unless there was a safety reason, for example if a person needed supervision to bathe safely. Communal rooms to the house were open but the front door was locked and chained, (the chain should be considered in terms of easy access in the event of the fire.) People could ask for access and people were supported to go out safely.

The environment for people was appropriate and the registered manager was working hard to ensure it was refurbished and gave more access. For example, to the garden and the laundry room so people's independence could be encouraged. Soft furnishings were comfortable and people had space and freedom to move around.

Is the service caring?

Our findings

At our last inspection to this service on 21 July 2017 we found this key question 'good'. At our inspection on the 23 July 2018 we found this key question remains 'good'.

Staff were familiar with people's needs and what they liked doing. We observed staff having a positive attitude and supporting people to be involved and as independent as they could be. One person was making a cup of tea, staff encouraged them and despite them being very unsteady, staff kept their distance guiding the person when appropriate to do so.

Care plans illustrated what people could do for themselves and what assistance they needed to be independent. People were mostly out throughout the day but we saw people as they were leaving or returning from a day out. They told us they liked the staff and told us about the things they enjoyed doing. We observed positive interactions with people and staff treating people with respect. Staff gave people appropriate choices in a way which was meaningful for them and we observed staff respecting people's privacy such as knocking on their bedroom door and waiting for a response.

Some people had sensory needs and there was guidance in place regarding how staff should meet people's specific communication needs. There was a lot of visual information around the service including a staff board photographs of all the staff to help people and visitors know who was on duty. There were also activity boards for individual use to help show what was planned for the day. Staff told us they used pictorial information to help people make choices and different methods of communication including Makaton.

Staff told us they acted on a person's behalf and facilitated contact with their family when this was something they wanted. They said they encouraged people to undertake different activities and helped ensure they did something each day.

We spoke with one member of staff who said people got continuity and there was little in the way of staff changes. They said it was a good team of staff who got on well and helped ensure people's needs were met. They described the service as, "A big family."

The registered manager told us how they had invested in their staff team and were proud to say they went the extra mile to meet people's needs. We asked for an example. They told us, "When people recently had a stay in hospital staff visited them in the own time to make sure they were okay and were being looked after." They also said in the recent poor weather, named 'the beast from the east' some staff walked in the snow several miles to get to work, and slept at the service, and covered those who were snowed in and unable to get to work.

Individual discussions were used to ascertain people's needs and how their care should be planned. People could say what they wanted to do and staff tried to facilitate this. People were consulted about the environment, and involved in care planning around their routines and changes to their needs.

Is the service responsive?

Our findings

At our last inspection to this service on 21 July 2017 we found this key question 'good'. At our inspection on the 23 July 2018 we found this key question 'requires improvement'.

At the last inspection the manager who was newly in post said they were going to review everyone's needs and care plans to ensure they were more personalised and reflected people's individual needs. We were unable to see how this had been achieved from the records we viewed.

Care plans did incorporate people's views of their care and support. They did describe routines and preferences and could be accessed by staff. Staff also knew people well and they provided support to people which was appropriate to their needs. However, we found information was not always complete or important information had been archived making it difficult for us to track through. For example, one person had their likes recorded but this was confined to five things and there was nothing recorded about what they disliked. Their weekly routine was the same but we saw little in the way of variety or providing the person with different opportunities. There was a space within the record to record a person's hopes and dreams but this was generic and not specific, individualised or measurable. We could not see progress towards helping the person achieve what they wanted. For example, it included what the person wanted to do, but not how this was going to be achieved, or by when.

Guidance in care plans was not always specific enough about how staff should support people should they become distressed. For example, 'support and encourage to calm down and reassure.' It did not give examples of what might trigger behaviours which some people could find challenging or how staff should respond to a person's changing needs. We saw one person had 1-1 support but there was little information about their needs or how staff should support the person in the least restrictive way.

Quarterly reports were completed to review people's needs but these were not sufficiently detailed and did not show progress made or changes to people's health care needs. We were assured there were robust records but many had been archived so some pertinent information was not on file. We found changes in people's care or treatment was not always reflected adequately in people's care plans or risk assessments. Information about health care needs was difficult to find, for example staff told us about a person's dietary needs but when we looked in their care plan there was nothing recorded about these. One person had recently been to hospital and required some follow up care/appointment but we could not see it documented in their care plan to show it happened or what if any changes to their care were needed.

From feedback it was clear that things had improved and people received a more personalised approach to their care needs. People were active and pursued things they enjoyed doing. Staff gave an illustration of things people had done recently. They told us everyone had their own bus passes and could access local community facilities. For example, people went swimming, went to a recent blues festival and the local carnival. Some people had one to one support, and staff worked flexibility to support people with their interests. Staff said there were usually enough staff to do things with people particularly as some people went home to their parents regularly at weekends.

We got positive feedback about day to day life in the home and both people using the service and staff had fun. People had keyworkers who were named staff who would oversee their care and support. One staff member took a person to see Daniel O'Donnell in concert and got to meet him backstage for photographs and autograph. One person told us they had enjoyed their trip to Edinburgh. They liked football and enjoyed bowling. It was clear people benefitted from things they liked to do.

A Halloween party night was held when the staff 'dressed up' for the occasion, one as a 'Zombie.' Cakes were made, and the house was themed with ghosts and ghouls. Family and friends joined in the celebrations and, prizes were given. A pyjama day to work and stalls at the fete were two examples of how the home were trying to raise funds for the home so a sensory room could be built.

No one at the service was receiving palliative care. The service knew people well and had documented people's preferences but there was nothing recorded about people's preferences regarding treatment on the onset of illness. Staff said over the years people had got older and they had supported people at the end of their lives and had done so with the involvement of advocates, family and relevant services such as district nurses to ensure people had the appropriate care both spiritual and emotional and any symptoms controlled and as far as possible.

The service had an established complaints procedure and information was accessible to those who might need it. There had not been any complaints about the service but we noted regular communication from management to staff, relatives and people using the service. This meant the early identification and resolution of issues before they became a complaint.

Is the service well-led?

Our findings

The service was not consistently well led. The registered manager told us they came into post four weeks before the last inspection to the service. They had since become registered and had relevant experience for their role. Since the last inspection they had worked tirelessly and although improvements were clear to see we were concerned that care records did not always support or reflect the care being provided. The quality assurance systems were not sufficiently robust in identifying gaps within the service which could pose as a risk to people's health, safety. We were not assured that the environment was as safe as it could be or that people always received the care according to their assessed and ongoing needs. At our previous inspection we rated well led as requires improvement with a breach of regulation 17 and felt the recent changes made within the service had not fully addressed the breach and improvements had not been sustained.

The above evidence demonstrated an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection they were going out to a registered managers forum where they shared ideas, best practice and supported each other through their experiences of managing registered services. The registered manager forum was run in conjunction with an organisation called skills for care, who lead on staff training and development for the care sector. They provide resources mostly free for care services to help them skill up their work force and support them to be compliant with relevant legislation.

The registered manager told us the journey they had been on with the staff and people using the service to help ensure the service was centred on the needs of individuals and was progressive. We asked them for examples of things they had achieved as a service and how this had impacted on people living there. They told us they took small steps to involve and encourage people to achieve. For example, people were now involved in planning the menus for the week by choosing meals and having options. They also did their own weekend shopping at the local supermarket. One person had their own mini fridge for beers and chocolate and we saw another person regularly had wine with dinner. People could have what they wanted.

The registered manager said a staff member had said to them, 'Thank you for showing me I can grow in my role and become a better person because of it' I have more confidence in what I do and say.' The registered manager had promoted staff internally and increased the amount of support/supervision for staff to help support them and grow in confidence. Staff spoke highly of the registered manager and said she acted on their feedback and upheld staff's confidence. Staff told us they respected the registered manager and she had helped move the service on.

Feedback was used as a way of identifying what the service did well and where it might need to improve. We saw recently surveys had been sent out to family asking them for their feedback. The findings were collated and an action plan developed where required. Individual comments/ concerns were responded to by the registered manager. The surveys produced limited information as many people had no or very little family connections so their views were not fully represented. However, the registered manager had thought about how to involve people and get their feedback and surveys had been designed around people's needs and

written in a way to help them understand the questions. The registered manager held a talking record which documented individual discussions with people about things that mattered to them such as trips they might like to have and things they wanted to do.

We received feedback about the service and viewed some recent feedback. It was clear that the service had undergone some positive changes but had in the past had several changes in both staffing and the management team. This had destabilised the service and in some areas the service had not been progressive. However, staff and relatives had confidence in the registered manager. They were described as responsive and was said to 'listen and take action.' Staff said people now had more opportunities to do what they wanted and went out more.

The registered manager had a clear vision for the service which they were still working towards. There was a board of trustees who oversaw the service and provided clinical governance and finance. They had become more involved with the service and now regularly visited to support the registered manager. The registered manager told us they had worked hard to change the culture within the service to make it more appropriate to the needs of people using the service. Their aim was for people to be as independent as possible and have increased opportunity to develop their skills and confidence and where appropriate, move to more independent accommodation. They saw a key challenge was to support the staff to enable them to feel more comfortable to let people make their own decisions and take calculated risks. They also said that since coming into post they had put in to place senior staff, one of whom had left, leaving two senior staff. They were supporting them to develop professionally and be able to effectively manage the staff team. They were supporting care staff in their personal growth and professional development but said some staff had left in the last year so they had not had the stability they would of hoped for. They also said they were making changes to the environment so it was appropriate and accessible to people's needs. There was a plan for upgrade and refurbishment. They were also raising money through stalls/events to install a sensory room/ area for people who would benefit from this.

The organisation's trustees had areas of specialism and defined roles who could be accessed by the registered manager. For example, there was a human resources manager who recently supported the registered manager to hold some performance management supervisions. This was carried out swiftly and effectively.

Accidents/incidents and concerns were collated showing what actions were taken and how people were safeguarded from actual or further harm.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not demonstrate through effective quality assurance systems how it was identifying areas requiring improvement to ensure people's health, care and welfare were fully met.