Pathway Care Solutions Limited

Little Acre - The Annex

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

We carried out an unannounced inspection of the service on 19 October 2017. Little Acre – The Annex is a small home which provides residential care for up to three people who have a learning disability and complex needs. On the day of our inspection three people were using the service.

At the last inspection, in September 2015, the service was rated Good. During this inspection we found concerns in relation to the safety of the service. This resulted in us finding a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to staffing. You can see what action we told the provider to take at the back of the report.

The service had 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.

During our inspection we found that the service was not consistently safe. There were not always enough staff to meet people's needs and ensure their safety and this placed people at risk of harm. The provider was aware of this and had had been proactive in trying to increase staffing levels. However, this remained a concern at the time of our inspection visit. Risks associated with people's care and support were assessed. However, these were not always effectively managed due to challenges with staffing levels.

People received their medicines as prescribed. Some improvements were required to ensure that medicines were safely managed. There were systems and processes in place to minimise the risk of abuse and safe recruitment practices were followed.

People were supported by staff who received training, supervision and support and staff had specialist training to enable them to meet people's complex health needs. People were enabled to make decisions and where they lacked capacity to make a certain decision, they were protected under the Mental Capacity Act 2005. People's nutritional needs were met and risks associated with eating and drinking were managed. People's health needs were monitored and responded to and this had a positive impact on their physical wellbeing.

Staff knew people well and were kind and caring in their approach. Staff understood how people communicated and when possible people were involved in making choices relating to their care. People had access to advocacy services if they required support to express themselves. People's diverse needs were recognised and accommodated and their rights to privacy and dignity were valued and respected.

People received care and support which met their needs and respected their preferences. Staff practice was not always consistent with guidance in support plans and improvements were required to ensure that staff

had access to accurate information. People were provided with opportunities for social activity at home and within the community. However the quality of activities was limited by staffing levels. There were processes in place to deal with complaints. We found that complaints had been recorded and responded to in accordance with the provider's policy.

The service was not consistently well led. There were systems in place to monitor and improve the quality and safety of the service. However, these were not always effective in identifying and addressing areas of concern and this resulted in action not being taken to address issues. We made a recommendation that improvements should be made in this area. People who used the service and their families were offered opportunities to provide feedback on the service and this was used to drive improvement. Staff felt supported and were involved in giving their views on how the service was run.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough staff to meet people's needs and ensure their safety.

Risks associated with people's care and support were assessed. However these were not always effectively managed due to challenges with staffing levels.

People received their medicines as prescribed. Some improvements were required to ensure that medicines were safely managed.

There were systems and processes in place to minimise the risk of abuse.

Is the service effective?

Good

The service was effective.

People were supported by staff who received training, supervision and support.

People were enabled to make decisions and where a person lacked capacity to make a certain decision they were protected under the Mental Capacity Act 2005.

People were supported to eat and drink enough and their nutritional needs were met. People had access to healthcare and their health needs were monitored and responded to.

Is the service caring?

Good

The service was caring.

People received care from staff who knew them and cared about their wellbeing.

People's diverse needs were recognised and catered for and their rights to privacy and dignity were valued and respected.

Staff understood how people communicated and when possible people were involved making choices relating to their care. People had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received care and support which met their needs and respected their preferences. Improvements were required to support plans to ensure that staff had access to accurate information.

People were provided with opportunities for social activity and were supported to access the local community. However the quality of activities was limited by staffing levels.

There were processes in place to deal with complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and improve the quality and safety of the service were in place, however these were not always effective in identifying and addressing areas for concern.

People who used the service and their families were offered opportunities to provide feedback on the service and this was used to drive improvement.

Staff felt supported and were involved in giving their views on how the service was run.

Little Acre - The Annex

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 comprehensive inspection was carried out on the 19 October 2017 by 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 reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider. We used this information to plan our inspection.

During the inspection we spoke with the relatives of all three people living at the home. We also spoke with four members of care staff, the assistant manager, the registered manager, the area manager, the provider's director of quality and the nominated individual. The nominated individual is a person who is nominated by the provider to represent the organisation.

We looked at care records relating to two people living at the home as well as the medicine records of all three people. We reviewed other records relevant to the running of the service such as, staff recruitment records, quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

People who lived at the home were not able to provide feedback on the service they received, due to the way they communicated and so we also carried out general observations of care and support also looked at the interactions between staff and people who used the service. In addition to this we used 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.

Requires Improvement

Is the service safe?

Our findings

Some relatives of people living at the home told us that they were concerned that there were not sufficient numbers of staff to respond to people's needs and ensure their safety. One relative told us that although every person living at the home required one to one support they had witnessed occasions where there were only two staff available to support all three people. They commented, "I don't feel that it is right that people are being left alone. They (provider) need to get it sorted; they are not providing what they pay for." This feedback was confirmed by the findings of our inspection. Due to their complex health needs all three people living at the home required the support of one member of staff and two members of staff for personal care. This level of support was not always provided. We reviewed rotas which showed there were occasionally only two members of staff deployed to support all three people. This was also confirmed by our discussions with staff. One member of staff we spoke with described staffing levels as 'challenging'.

The failure to ensure sufficient numbers of staff placed people who used the service at risk of harm. Although we saw that risks were assessed and individualised plans put in place to minimise these, we received concerns during the course of our inspection, from family members and external health professionals, that reduced staffing levels meant staff were not always available to ensure people's safety. For example, one person was at high risk of causing injury to themselves and required constant supervision from staff. However, staff told us there were occasions where both staff were required to assist other people and consequently this person was left without direct supervision. Staff told us that they ensured the person's safety by using video monitors to observe them remotely. This did not assure us that staff would be available to intervene as quickly as required to prevent the person from harming themselves. The outcome of a recent safeguarding investigation conducted by the local authority also highlighted concerns about the impact of insufficient staffing levels, on the ability of the staff team to manage risk effectively and provide safe support.

We spoke with the nominated individual who was aware of the staffing difficulties and told us that a number of factors had led to this. They told us that they were working to resolve staffing issues through the recruitment of new staff, by exploring ways to support staff to get in to work such as offering support with driving lessons and to purchase vehicles and by enhancing staff benefits to try to and attract and retain staff. Despite this we found that staffing levels remained insufficient.

We also found staff were not effectively deployed. When we arrived at the home there were two members of staff on shift, both of whom were restricted in the amount of moving and handling they could undertake. One member of staff informed us that this meant they had to leave 'heavier' duties until the day staff came on shift at 10am. This meant that these staff were not sufficiently competent to meet the needs of people who used the service and this placed people at risk of not receive the support they required.

The above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents were recorded and reviewed and we saw evidence that, in the majority of cases, action had been

taken to try to prevent recurrence. For example, one person had sustained an injury whilst having their medicine administered. As a result staff had been provided with additional training and alternative equipment had been purchased to prevent further occurrences. However, we saw some evidence that action taken to try to prevent further incidents was not always effective. One person had previously choked on an object. Action had been taken to investigate the incident and risk assessments had been updated as a result. This specified that the person must be closely observed when handling certain objects. However during the course of our inspection we were notified by the provider of another similar incident which had occurred. This meant that we could not be assured that all practicable steps had been taken to reduce the risks to the person.

Relatives of people living at the home told us that people received their medicines as required and this was supported by records. However, during our inspection we identified a number of concerns about the management of medicines. Medicines records written by the service were not checked to ensure information had been recorded correctly. Although we saw that information on medicines records was accurate this failure to check records meant there was a risk that errors and inaccuracies may not be identified. Records relating to controlled drugs did not accurately reflect the actual amount of medicines in stock. Controlled drugs require special storage and recording due to their potential for abuse. Where people were prescribed creams for application on specific areas of their body, staff did not have access to guidance about where these creams should be administered. Some people had medicines which were prescribed to be given 'as required', but we found that there were not always protocols in place detailing when these medicines should be given. This meant that staff did not always have clear information about when to give people these medicines and posed a risk that they may not be administered when needed. Liquid medicines were not always dated when opened. This is important to ensure medicines are not used beyond their expiry date. When people were prescribed a medicated skin patch, records did not show where on the body the patch had been applied. This meant people were at risk of experiencing side effects such as skin irritation. The above issues posed a risk that people may not receive their medicines as prescribed.

We received mixed feedback from relatives about the safety of the service. One relative told us there had been times where they had not felt their relation was safe but also added that they did not have any current concerns except about staffing levels. Another relative told us about a number of current concerns they had about the service. These concerns were being investigated by the local authority safeguarding adults team at the time of our inspection visit and investigations were ongoing at the time of writing this report. Staff we spoke with had training in safeguarding people from abuse and had an understanding of how to recognise allegations or incidents of abuse. Staff told us they understood their role in reporting any concerns to the management team and escalating concerns to external agencies if needed. Records showed that the assistant manager had shared information with the local authority safeguarding adult's team when there were concerns.

Risks associated with the environment had been assessed and planned for appropriately. Risks in relation to the water from acquiring legionella had been assessed. The fire systems in the service were checked and maintained at regular intervals.

People could be assured that safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and competency to provide good quality care and support. New staff were provided with an induction period when starting work at the service. The assistant manager told us that staff induction included training and shadowing of more experienced staff and this was confirmed in our discussions with staff. New staff were also in the process of completing the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support. Staff were positive about the ongoing training and support they received. The assistant manager told us that the provider has made a significant investment in training over the past 12 months. Records showed staff had received the relevant training to equip them with the knowledge and skills they needed to support people who used the service. This included specialist training to ensure that staff had the skills to meet the complex health needs of people who lived at home. Staff we spoke with were knowledgeable about systems and processes in the service and about aspects of safe care delivery. Staff told us and records showed they had regular formal and informal opportunities to discuss and review their work, training and development needs.

The Mental Capacity Act (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. We checked whether the service was working within the principles of the MCA.

We found staff had a good working knowledge about their duties under the MCA and how to support people with decision making. The provider had taken steps to ensure people's rights were protected. For example, one person living at the home was subject to significant restrictions on their right to privacy, the provider had taken action to request independent professional support to ascertain if this was in the person's best interests. People's support plans contained information about whether people had the capacity to make their own decisions. Assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made. We found that the quality of capacity assessments were variable and some further work was required to evidence how people's capacity had been assessed and decisions made in people's best interests also required more detail. We discussed this with the assistant manager who informed us that further work would be done to ensure capacity assessments were sufficiently detailed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The assistant manager had made applications for DoLS where appropriate and some of these had been granted. They told us that there were no conditions stated on any of the DoLS that had been

granted.

People were supported with their nutritional needs. People living the home had complex needs in relation to their nutrition and hydration and relied upon staff to ensure these needs were met. People's care plans contained clear guidance for staff to follow and this was also available in the kitchen. Staff had received training in meeting people's nutritional needs and staff we spoke with and observed, demonstrated a good knowledge of people's needs. We received positive feedback from a health professional who told us that the staff team were effective in managing people's nutritional needs. Where people had risks associated with eating and drinking, such as choking, there were clear plans in place about how to manage this and we observed that staff followed this guidance. People were provided with a choice of home cooked food and their cultural preferences were taken into account in the preparation of meals.

The staff team were proactive in ensuring that people maintained a healthy weight and had taken action in response to fluctuations in people's weight. For example, the nominated individual told us they had addressed concerns about one person's low weight. This had resulted in the person receiving hospital treatment and consequently the person had gained significant amounts of weight and their physical wellbeing had improved.

People were supported with their day to day healthcare needs. People were given support to attend regular appointments and to get their health checked. People had their healthcare needs detailed in their support plan. Records showed where people's needs changed staff sought advice from healthcare professionals and followed the recommendations they made. The relative of one person told us they had discussed some concerns about their relation's health and the staff team had acted quickly to access support from specialist health professionals. A healthcare professional commented, "The home are open to taking advice and will implement changes as recommended." This had a positive impact on people who used the service and we received feedback from staff and relatives that people's health had significantly improved and stabilised whilst living at the home.

Good

Is the service caring?

Our findings

People's relatives and health and social care professionals involved with the service were, on the whole, positive about the approach of the staff team. One person's relative told us, "I have no doubt that the staff are kind and caring." Another relative commented, "I feel that the carers are kind and caring. [Relation] is happy, clean and tidy. I would know if [relation] was unhappy." Health care professionals commented that staff were 'attentive' and said that staff provided an 'exemplary service'. We received some concerns from another relative about the approach of the staff team, these concerns were being investigated by the local authority safeguarding team at the time of writing this report. Throughout our inspection we observed warm, caring, friendly interactions between people living at the home and staff. People appeared to enjoy the company of staff and were calm and comfortable in their presence. Staff were affectionate towards people and told us they cared very much for them. One member of staff told us, "I enjoy it here, I love the personalities of the young adults."

Staff had an understanding of what was important to people and their support plans contained personalised information about their interests and preferences. People's bedrooms were personalised, homely and reflected what was important to each person. People's diverse needs had been taken in to account in the decoration of their rooms, for instance, one person had religious beliefs which required that religious items were stored in specific locations, we saw this was reflected in their support plan and followed in practice.

Staff endeavoured to communicate with people in a way they would understand and where possible people were involved in decisions about their support. Support plans contained clear and detailed information about how people communicated. Staff demonstrated a good understanding of people's communication needs and used this to involve people in day to day decisions. Throughout our inspection visit we observed staff involved and included people in decisions by observing their non-verbal communication and body language. The staff team had made adjustments to accommodate people's diverse needs in relation to communication. For example, one person required support to read their religious text, a member of staff who shared the same beliefs frequently read this to the person as they were unable to read themselves and they also had an audio version which staff enabled them to listen to.

During our visit we observed there was no information about independent advocacy services displayed in the service and there were no links with a local advocacy service. Advocates are trained professionals who support, enable and empower people to speak up. The assistant manager explained they would contact the person's social worker if they thought someone might need an advocate to help them speak up and told us they had recently done so.

People's rights to privacy and dignity were respected. We observed people's privacy was respected throughout our visit. Staff knocked on people's doors before entering, they ensured that bedroom and bathroom doors were closed during care. Staff also respected people's right to confidentiality. Conversations about people's support needs were held in areas that could not be overheard.

People were given the opportunity to discuss their wishes and preferences in relation to care at the end of their lives. Staff had supported people's families to develop plans for the end
of their loved one's lives and this was sensitively recorded in people's support plans. We reviewed an end of life care plan for one person and saw this detailed what was important to the person and their wishes for after their death. The nominated individual told us care had been taken to ensure that people's cultural and religious wishes had been taken into account when considering the care and treatment of people at the end of their lives. The staff team had worked with the family of one person to ensure they understood important religious rituals for end of life care so when the time came the person and their family could be assured that their wished would be respected.

Requires Improvement

Is the service responsive?

Our findings

Feedback about the support provided at the service was variable. Some relatives told us their relation experienced care and support that met their needs and preferences. However, another relative expressed concerns that their relation did not always receive the care and support they required. We found support plans were in place for each person living at the home. These had been developed in partnership with the families and also included information from members of the staff team who knew people well. Support plans contained information about what was important to people and what support people required to stay safe. The majority of information in these plans was accurate and up to date and staff demonstrated a good knowledge of people's support needs. We did identify some areas where the support staff were providing varied from that specified in the support plan. This posed a risk that people may receive inconsistent support. We discussed this with the area manager who assured us that action would be taken to bring the support plans up to date.

People were provided with opportunities to get involved in activities at the home and were also supported to access the community; however staff told us that this varied depending upon staffing levels. Records showed staff facilitated activities that were accessible to people living at the home such as sensory activities, reading books and music. Staff told us they tried to ensure that people had enough to do with their time, but also said on days where only two staff were available to support all three people they had to focus on tasks such as personal care. This meant there were occasions when the time staff had to spend with people doing activities was limited. A member of staff told us this meant that people were occupied with DVDs and CD's at these times to enable staff to focus on essential tasks. This was evident in records, for example records for one person showed they watched four films in one day, this was a day when there were only two staff available. However records also confirmed that people were enabled to access the local community and to engage in educational activities such as college courses. Staff told us and records showed that people living at the home had enjoyed activities such as trips to the theatre, ice skating and swimming. The staff team at the home had worked to overcome barriers to inclusion. For example, staff told us and records showed they had successfully lobbied a local college to train staff, so that they could accommodate the health needs of one young person living at the home. This had resulted in the person being able to attend college with their peers.

People were supported to go on holiday and we saw photos of people enjoying a recent trip to the coast. A member of staff explained this recent trip had had a very positive impact on one person who used the service, they said, "I have never seen [person's name] so relaxed." The service had a well maintained, accessible garden and staff told us that this was used regularly for social events in the summer months.

The service had links with the local community and were passionate about building upon this further. Members of the local community were invited to attend fundraising events, such as coffee mornings, at the home. Proceeds of these events were then donated to local charities. The home were also planning a bonfire event which the neighbours and local community were invited to. People were supported to maintain relationships with friends and family. There were no restrictions upon people's families visiting the home. We spoke with a relative who told us they and their family were invited to join their loved one in some

community based activities.

People's diverse cultural and religious needs were identified and accommodated. For example, one person had specific cultural needs. The provider had recruited a specific member of staff from the same cultural background and this member of staff had worked with the staff team to help them understand and cater for the person's diverse needs. We spoke with a member of staff who told us this had resulted in the staff team gaining a better understanding of how to respect the person's needs and why this was important. During our inspection visit we observed that the person's daily religious routines were understood and respected by staff.

We received mixed feedback about the management of complaints. The relative of one person told us they felt comfortable to raise concerns and confident that these would be addressed by the management team. In contrast another relative told us they did not feel assured that complaints would be handled effectively without the fear of repercussions. During the course of our inspection we were made aware of one person living at the home who had been served with their notice and asked to find alternative accommodation. The nominated individual confirmed this decision had been made as they felt unable to continue to provide care to this person due to the impact of complaints which had been made on their behalf.

There were systems in place to record and respond to complaints made about the service. A complaints procedure was on display in the home informing people how they could make a complaint. Staff we spoke with were aware of the procedure and their role in recording any concerns received and communicating these to the management team. We reviewed records of recent complaints and saw the provider was currently in the process of investigating a complaint. There were records in place which demonstrated the provider had followed their policy and conducted investigations of concerns raised. The nominated individual informed us the complainant was not satisfied with the outcome of the complaint and consequently this had been progressed to the next stage of investigation in accordance with their policy.

Requires Improvement

Is the service well-led?

Our findings

Swift action had not always been taken in response to concerns raised in audits conducted by external agencies. Prior to our inspection visit we reviewed the findings of audit conducted in June 2017 by Nottinghamshire Clinical Commissioning Group (CCG). This had identified concerns related to medicines management, care planning and the application of the Mental Capacity Act. Action had not been taken to address the areas for improvement identified in the audit. For example, the CCG audit found the records relating to controlled drugs were not accurate and during our inspection we found that this continued to be an issue. Following our inspection visit the assistant manager informed us that they had arranged to meet with the CCG to develop an action plan to address the areas of concern.

The provider had systems and processes in place to monitor the quality and safety of the service and checks were completed on a regular basis including the safety of the environment, medicines management, care records, staffing and training. Monthly reports were completed for each person as a method of reviewing people's progress. A member of the provider's quality assurance team conducted regular audits at the home. We saw these systems were, on the whole effective in identifying and addressing most issues. However, the issues we identified during our inspection in relation to medicines management had not been identified by the audits conducted by the manager or quality assurance team.

We recommend the provider further develops its audit and quality assurance processes to ensure they are effective in identifying and addressing areas for improvement.

The service had a registered manager in post who was also responsible for running a children's service which was located on the same site. The provider informed us that the assistant manager took day to day responsibility for the running of the home and the registered manager had informal oversight of the service. Consequently they were planning to change the management arrangements to ensure there was a registered manager in post who held responsibility for the day to day running of the service. We checked our records which showed the assistant manager had notified us of events in the service. A notification is information about important events which the provider is required to send us by law such as serious injuries and allegations of abuse. This helps us monitor the service.

The assistant manager explained they kept up to date with good practice in a number of ways. This included involvement in meeting with other local managers of both children's and adults services, internet research and by reading updates provided by national good practice organisations. The assistant manager told us they felt supported by the provider and were given resources to ensure the provision of a high quality service. For example, they had been informed that visits from the dietician would be reduced to monthly, they raised concerns with the provider about how they would effectively monitor people's weights and the provider swiftly purchased wheelchair scales for the service. They also told us the provider made a significant financial contribution towards each person's annual holiday every year. The nominated individual had a vision of equality and inclusion for the people who used the service, they explained that this guided the development of the service.

Staff we spoke with were positive about the management of the service and the support they received. One member of staff told us, "[Assistant manager] makes you feel welcome and always has time for you." Another member of staff said, "[Assistant manager] is supportive, they will listen to staff, very approachable. Brilliant! They work very hard." Heath and social care professionals were also positive about the leadership of the service. One healthcare professional commented that the assistant manager was organised and always provided the information requested in a timely manner. Feedback from relatives about the management of the service was mixed. One relative told us, "I feel the service is well led, [Assistant Manager] is very approachable, I can raise things and concerns get sorted. It's all very positive, I would recommend it to other people." However another relative had very limited confidence in the management and leadership of the service and told us they felt this had a negative impact on the care and support experienced by their loved one.

We also received mixed feedback about the quality of communication with people's families. One relative was positive about communication and told us that they were provided with timely updates about their loved one's support. In contrast another relative told us that communication was poor. A third relative told us that there had been issues with communication in the past but that this had improved over the past 12 months.

There were regular staff meetings in which staff discussed issues, concerns and the wellbeing of people who used the service. Staff were given the opportunity to thank and appreciate their colleagues and these compliments were shared in team meetings. Compliments were recorded and shared with the staff team to celebrate good practice. For example, a healthcare professional had recently complimented the staff team on the quality of their support plans and this had been shared with the staff team. Staff told us that they felt their ideas and opinions were listened to and used to improve the service. Staff had a good understanding of their roles and were aware of the whistle blowing policy. A 'whistle-blower' is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation. We spoke with a member of staff who explained that they had previously raised a concern with the management team, this had been handled sensitively and the issue had been resolved.

People who used the service were invited to attend regular meetings. Records showed that these were used to share information with people and trips and events were discussed. It was clear that staff had used creative techniques to try and involve people and make meetings meaningful for them, such as using sensory objects to describe events. The assistant manager told us that people's relatives were encouraged to be a part of the running of the home. Relatives were invited to regular 'parents forum' meetings and had been consulted about things such as the decoration of the home. Annual satisfaction surveys for people's relatives were also conducted. Responses to the most recent survey were mixed. Some relatives provided very positive feedback about the quality of the service at Little Acres – The Annex. Significant concerns had been raised by other relatives and we saw records to demonstrate that these concerns were ongoing and were being managed through the complaints procedure.

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 18 HSCA RA Regulations 2014 Staffing There were not always enough staff available to meet people's needs and ensure their safety. Regulation 18(1)