Modus Care Limited

The Tobias Centre

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 17 and 24 May 2018.

At the previous inspection in January 2017 we found three breaches of regulations. Risks associated with people's personal safety or behaviours that may be challenging to others were not always identified; some areas of the service had an institutional appearance; care plans were not always regularly and thoroughly reviewed and documented and systems in place to monitor the quality of care being provided were not always effective. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) safe, effective, responsive and well-led to at least a rating of good. This inspection found improvements had been made and the service was now meeting these regulations. However, we found a new breach regards to medicines management and infection control.

The Tobias Centre is a 'care home' which provides accommodation and personal care for up to seven people with learning disabilities and autistic spectrum conditions in one adapted building. 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. At the time of our inspection there were six people living at the service.

The care service has 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.

There was a new 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.

Medicines management was not robust. On the first day of our inspection we found the medicines keys were not secure; some 'as required' medicines protocols were not in place to guide staff and hand written entries on medicines records were not signed and checked to show the information was correct. By the second day of our inspection, the issues were starting to be addressed. This included ensuring staff had the medicine keys on their person.

People were not fully protected from cross contamination. On the first day of our inspection we visited the laundry and found the laundry contained discarded, dirty equipment, including seating and a washing machine not now functional. The room was unclean, and not readily cleanable, posing an increased risk of cross contamination. The one sink was particularly dirty and there was no soap or towels for staff to wash their hands. By the second day of our inspection the issues had been addressed. The laundry room had

been thoroughly cleaned, the washing machine removed and the sink was accessible with soap and hand paper towels.

Systems in place to monitor the quality and safety of the service were not always effective. Checks had failed to identify the issues around medicines management and infection control.

The service provided safe care to people. Measures to manage risk were as least restrictive as possible to protect people's freedom. People's rights were protected because the service followed the appropriate legal processes.

Care files were personalised to reflect people's personal preferences. Their views and suggestions were taken into account to improve the service. People were supported to maintain a balanced diet. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate. People's social and emotional needs were met through meaningful activities both within the home and local community.

There were effective staff recruitment and selection processes in place. People received effective care and support from staff who were well trained and competent.

Staff spoke positively about communication and how the registered manager worked well with them and encouraged their professional development.

We found one breach of Regulation in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

The security of stored medicines was not safe. There was a lack of protocols in place to guide staff administer as required medicines. Records needed improving.

People were not fully protected from cross contamination. However, action was taken to address the concern.

People's risks were managed appropriately in order to keep them safe.

Staffing arrangements met people's individual needs.

There were effective recruitment and selection processes in place.

The premises was kept in a safe condition.

Is the service effective?

Good

The service was effective.

Staff received a range of training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well through regular contact with community health professionals.

People's rights were protected because the service followed the appropriate guidance.

People's individual needs were met by the adaptation, design and decoration of the premises.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

Staff relationships with people were caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support specific to their needs, preferences and diversity.

Activities formed an important part of people's lives.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

One aspect of the service was not well-led.

Systems in place to monitor the quality and safety of the service were not always effective. Checks had failed to identify the issues around medicines management and infection control.

Staff spoke positively about communication and how the registered manager worked well with them and encouraged an open culture where they could express their opinions.

People's families felt the registered manager was very helpful and listened to them.

People's views and suggestions were taken into account to improve the service.

The Tobias Centre

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 17 and 24 May 2018.

The inspection team consisted of two adult social care inspectors on the first day and one inspector on the second day.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events, which the service is required to send us by law.

We spoke to nine members of staff, which included the registered manager and members of the organisation's behaviour support team. We also spent time in communal areas observing the interactions between people and staff.

People living at the service were unable to communicate their experience of living at the home in detail with us as they were living with a learning disability. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We reviewed three people's care file, five staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. After our visit we sought feedback from relatives and health and social care professionals to obtain their views of the service provided to people. We received feedback from two relatives and two professionals.

Requires Improvement

Is the service safe?

Our findings

Some aspects of medicines management were not safe. Medicines keys were kept on a hook in the kitchen and could be accessed by any staff member or person using the service who might be in the kitchen unsupervised. Those keys were used to open a medicines room and a key safe in that room, where other keys were kept. These including those for a cupboard containing drugs classed as needing specialist storage, called controlled drugs. The service' medicines guidelines, in each person's file, stated that: 'The senior member of staff will keep the medication keys on them…' The deputy confirmed this did not currently happen. This meant that staff were not following the service' guideline, or safe practice.

For some 'as required' medicines the information for staff was detailed and clear. This meant that those medicines could be given consistently and appropriately. However, one person was to take one medicine at night and one in the morning 'when required'. There was no protocol to inform the staff when the morning medicine could be given. Another person was prescribed a tablet to be given twice a day with an extra one 'when required'. Again, there was no information to inform staff when this was appropriate. This meant that tablets might not be given consistently. However, when a medicine was given this was recorded by two staff, who we presume had agreed it was needed.

Sometimes medicine administration records are not be completed by a pharmacy and so staff transcribe information from the medicine packet to a medicine administration record. This can pose a risk of mistake. We looked at five hand written entries onto medicine administration records. Four of the five entries were unsigned and so there was no record of who had written the information. The fifth may have had a signature, but it was not clear. There was nothing to suggest the entries had been checked as correct, which posed a risk that that information staff were following was not correct.

By the second day of our inspection, the issues were being addressed. This included ensuring staff had the medicine keys on their person.

Medicine management was safe but could be improved. Medicines in packets were being used out of sequence, which complicated any audit.

Other aspects of medicine practice were safe and protected people. For example, the temperature in which medicines were stored was checked daily, information leaflets were stored in each person's own, individual, medicines record file. Information about any allergy was clearly stated and there was a detailed protocol for when medicines were taken out of the home. Medicine records were checked against stock, and if the stock did not match the record then this was highlighted in red, indicating some action was needed. Staff said they received training in how to administer medicines. People's medicines were under regular review.

People were not fully protected from cross contamination. The main building was clean and fresh. Staff said that they received training in infection control and they had all necessary protective equipment (such as gloves) available to them. On the first day of our inspection we visited the laundry and found the laundry contained discarded, dirty equipment, including seating and a washing machine not now functional. The

room was unclean, and not readily cleanable, posing an increased risk of cross contamination. The one sink was particularly dirty and there was no soap or towels for staff to wash their hands. The deputy manager said, "It's not even clean enough to wash your hands." The registered manager said they would have the laundry cleared and cleaned as a priority. The equipment in use would meet the personal needs of people using the service. However, there was no separate machine for kitchen laundry, such as tea towels.

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

By the second day of our inspection the issues had been addressed. The laundry room had been thoroughly cleaned, the washing machine removed and the sink was accessible with soap and hand paper towels.

At the previous inspection in January 2017 the safe question was rated as requires improvement. Risks associated with people's personal safety or behaviours that may be challenging to others were not always identified. The terms seclusion (where people are isolated from others and prevented from leaving) and restraint (where people's movements and their freedom to act independently is restricted) were not fully understood by staff. This inspection found improvements had been made.

Positive Behaviour Support (PBS) plans had been developed for people who could at times, display behaviours which could place them or others at risk of harm. The PBS plan also included guidelines for staff about the use of physical intervention and how and when these may need to be used. The types of physical interventions used included 'assisted support', 'two person removal' and 'seated restraint.' The service was working closely with health and social care professionals, including the Intensive Assessment and Treatment Team (IATT) to develop plans for staff to follow to ensure people's safety in line with best practice.

Staff demonstrated a good understanding of how to manage people's behaviours. These included recognising triggers which could lead to an increase in people's anxieties. Staff knew to use distraction techniques in the first instance, such as suggesting an activity or focusing on another task, such as having a cup of tea. Professionals commented: "From my perspective the behaviour team staff and managers appear to have increased their engagement. I'd say that (registered manager) seems to have put some significant effort into engaging with us around (PBS) and to making some of the practical changes within the home. If I had to highlight one person in the process for commendation it would be her, due to her heartfelt engagement with our guidance in reducing the levels of restrictive practice. From general experience of visiting, the home seems to be a more positive place. Staff appear to be more engaged with individuals in the home and less 'poised and waiting' for behavioural challenges to occur, and it feels like a nicer place when you come through the door. My impression is that (registered manager), with support of (behaviour support team), seems to have been the driving force behind this" and "(Person's) challenging behaviours have reduced in intensity and frequency. The reductions we have seen have been due to the diligence of the staff in following agreed care plans."

We saw that a detailed protocol for the use of seclusion had now been drawn up. This highlighted the need to ensure lesser restrictive interventions were used prior to any seclusion. Details of the lesser restrictive practices were outlined in the behavioural support plan. Staff reporting of incidents to ensure accuracy had improved and certain staff were receiving additional mentoring to ensure they were fully aware of the detail needed in the incident paperwork. Incident forms showed that staff were attempting more distraction techniques which was less restrictive. Where incidents had occurred they were analysed by the organisation's behaviour management team to look for any specific trends and causes. This had enabled PBS plans to be updated. As a result, there had been a noticeable reduction in incidents occurring because of an adoption of proactive practices.

Staff were provided with Positive Behavioural Management (PBM) training which was BILD (British Institute of Learning Disability) accredited, and the behavioural support team regularly received training to keep them updated. One staff member said "It is the policy that staff do not even start working in the home until they have completed their PBM training." This showed that the organisation took safety seriously to ensure people were supported appropriately.

For some risks, management plans had been developed to ensure support staff knew how to support people safely and minimise any risks. For example, there were detailed plans in place to minimise risks when people were out walking to the shops and travelling in vehicles.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, changes to a person's care plan and risk assessment to reflect current circumstances. Actions had been taken in line with the service's policies and procedures. Where incidents had taken place, involvement of other health and social care professionals was requested to review people's plans of care and treatment. The service was both responsive and proactive in dealing with incidents which affected people.

People living at the home were not able to comment directly on whether they felt safe. We spent time in communal areas and spoke with staff to help us make a judgement about whether people were protected from abuse. Staff responded appropriately to people's needs and interacted respectfully to ensure their human rights were upheld and respected. Interactions between people and staff were relaxed and friendly and people were happy in staff presence. Relatives commented: "(Staff) keep (relative) safe. They really understand him. So mindful when integrating new staff" and "I know (relative) is safe. (Relative) has had several placements and this is the best."

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission (CQC). Staff records confirmed staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

The registered manager demonstrated an understanding of their safeguarding role and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. There were clear policies for staff to follow. Staff confirmed they knew about the provider's safeguarding adults' policy and procedure and where to locate it if needed. Safeguarding had also been reported appropriately to both the local authority and CQC.

Staff confirmed that people's needs were met promptly and they felt there were sufficient staffing numbers. We observed this during our visit when people needed support or wanted to participate in particular activities. For example, staff spent time with people engaging in a range of activities both within the home and local community.

The registered manager explained that during the daytime everyone received at least one to one support. In addition, staffing levels increased dependent on what activities people had planned. At night, there were two waking night staff. We asked how unforeseen shortfalls in staffing arrangements due to sickness were managed. They explained that regular staff would fill in to cover the shortfall, so people's needs could be met by the staff members who knew and understood them. Agency staff were very rarely used and if this was necessary they would undertake tasks such as cooking and cleaning, and would not work unsupervised with people using the service. In addition, the service had on-call arrangements for staff to contact if

concerns were evident during their shift. The on-call arrangements were shared between members of the organisation's management team.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. The DBS is a criminal records check which helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

The premises were adequately maintained through a maintenance programme. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. People had personal emergency evacuation plans (PEEPs), which are individual plans, detailing how people will be alerted to danger in an emergency, and how they will then be supported to reach safety. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care.

Good

Is the service effective?

Our findings

At the previous inspection in January 2017 the effective question was rated as requires improvement. Some areas of the service had an institutional appearance, especially those areas that had been adapted to maintain people's safety. This inspection found improvements had been made and were on going.

People's individual needs were met by the adaptation, design and decoration of the premises. A 'maintenance and refurbishment plan' had been implemented to address areas around the home. A stable door had been removed from one of the rooms used to support a person when they became anxious and other areas had been redecorated and modernised. For example, bedrooms were very nicely completed, modern, fresh and attractive with modern wet rooms of a high standard. People were encouraged to choose colours and furnishings for their bedrooms. One person had achieved this by using a tablet to make the choices.

People did not comment directly on whether they thought staff were well trained. However, we observed people were happy with the staff who supported them. Relatives commented: "The staff are well trained and new staff watch and learn when they start" and "I know they (staff) have lots of training, always sent on training to keep up to date."

Staff knew how to respond to specific health and social care needs. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported with personal care. Staff felt people's care plans and risk assessments were "really useful" in helping them to provide appropriate care and support on a consistent basis. For example, when recognising changes in a person's physical or mental health.

People were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, GP, psychiatrist, learning disability practitioner and social worker. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. For example, the service was working closely with the Intensive Assessment and Treatment Team (IATT) on an on-going basis to ensure people's behaviours were managed appropriately. People also had hospital passports. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

Staff had completed an induction in line with the Care Certificate when they started work at the service. The Care Certificate sets a minimum standard that should be covered as part of induction training of new care workers. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. The induction enabled the organisation to assess staff competency and suitability to work for the service.

Care was taken to ensure staff were trained to a level to meet people's current and changing needs. Staff

received a range of training, which enabled them to feel confident in meeting people's needs, recognising changes in people's health, for example. They recognised that in order to support people appropriately, it was important for them to keep their skills up to date. Staff received training on subjects including, safeguarding vulnerable adults, the Mental Capacity Act (2005), behaviour management, autism awareness and first aid. Staff had also completed varying levels of nationally recognised qualifications in health and social care. Staff commented: "Just done autism. Very interesting and a nice day" and "The training I received has helped me to do my job."

The organisation recognised the importance of staff receiving regular support to carry out their roles safely. A new supervision and appraisal calendar had been implemented by the registered manager as staff supervisions had lapsed. Staff confirmed that they felt supported when it came to their professional development. One staff member commented: "Due to all the changes, initially, there was no staff support at all. I've noticed a big difference since I've been here. Team spirit is on the up."

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted their bedroom redesigned.

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

People's legal rights were protected because staff knew how to support people if they did not have the mental capacity to make decisions for themselves. People's capacity to make decisions about their care and support were assessed on an on-going basis in line with the Mental Capacity Act (MCA) (2005). For example, where staff were concerned about a person's behaviour and their lack of capacity to make decisions and manage their emotions, they had worked closely with other health and social care professionals. People's capacity to consent had been assessed and best interest discussions and meetings had taken place. For example, for suitability of placement. This demonstrated that staff worked in accordance with the MCA.

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 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 registered manager had liaised with appropriate professionals and made applications for people who required this level of support to keep them safe. Six people had authorised DoLS in place at the time of our inspection and the service was meeting the conditions. For example, the use of less restrictive practices before the need for seclusion and/or restraint.

People were supported to maintain a balanced diet. People were actively involved in choosing what they wished to eat with staff support to meet their individual preferences. A staff member commented: "(Person) will choose what they would like to eat from the kitchen." Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. Staff

recognised changes in people's nutrition with the need to consult with health professionals involved in people's care. People's weights were monitored on a consistent basis to ensure their general well-being.

Good

Is the service caring?

Our findings

The service continued to be caring. We spent time observing the interactions between people and staff. Interactions were good humoured and caring. We observed how staff involved people in their care and supported them to make decisions. For example, how they wanted to spend their day. Staff were seen to use people's preferred communication methods confidently when talking with them about things that interested them. For example, staff were using sign language with one person to establish their needs and what they wished to do. Relatives commented: "The staff are very good, they love our son and are very fond of him" and "Lovely staff, they are really caring. Ten out of ten."

Staff treated people with dignity and respect when helping them with daily living tasks. People's bedrooms gave them privacy and space to spend time on their own if they wished. Bedrooms reflected people's specific interests, such as pictures and posters on the walls. Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. Staff promoted people's equality, diversity and ensured their human rights were upheld. For example, staff recognised how choice of how people spent their day was important to them to ensure their individuality.

Staff adopted a positive approach in the way they involved people and respected their independence. For example, supporting people to make specific activity decisions. People were completing a variety of activities and accessing the local community during our inspection. Staff supported people in an empathic way. They demonstrated this empathy in their conversations with people they cared for and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, one person enjoyed staff talking to them about things of interest to them; this provided them with reassurance.

Staff gave information to people, such as when activities were due to take place. Staff communicated with people in a respectful way. Staff relationships with people were caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported. Staff offered care that was kind and compassionate. Staff demonstrated how they were observant to people's changing moods and responded appropriately. For example, if a person was feeling anxious. They explained the importance of supporting them in a caring and calm manner by talking with them about things which interested them and made them happy. Staff recognised effective communication as an important way of supporting people, to aid their general wellbeing.

Staff showed a commitment to working in partnership with people. Staff spoke about the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued. Staff spoke of the importance of empowering people to be involved in their day to day lives. For example, what activities they wished to complete and how they wished to be supported with personal care. They were able to speak confidently about the people living at The Tobias Centre and each person's specific interests. They explained that it was important that people were at the heart of planning their care and support needs and how people were at the centre of everything. We observed staff working alongside people throughout our

inspection at a pace which suited the individual.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. Care plan reviews were happening on a regular and timely basis and as far as possible people were involved in these utilising preferred communication methods.

Care files gave information about people's health and social care needs. They were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. For example, supporting people to identify specific activities to aid their wellbeing and sense of value. A staff member commented: "We work well as a team and ensure a relaxed atmosphere."

Care files included personal information and identified the relevant people involved in people's care, such as their GP. Relevant assessments were completed and up-to-date, from initial planning through to on-going reviews of care. Staff commented that the information contained in people's care files enabled them to support them appropriately in line with their likes, dislikes and preferences. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as, their physical and mental health. People's likes and dislikes were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

Care plans were up-to-date and were clearly laid out. They were broken down into separate sections, making it easier to find relevant information. For example, physical and mental health needs, personal care, communication, social activities and eating and drinking. Staff said they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health. Staff commented: "The care plans really help me to support people appropriately" and "The care plans enable me to recognise when people's needs are changing."

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People receiving support had a learning disability and varying communication abilities. Staff were able to communicate with, and understand each person's requests and changing moods as they were aware of people's known communication preferences. Care records contained clear communication plans explaining how people communicated and information about key words and objects of reference they used to express themselves. The service used a variety of communication tools to enable interactions to be led by people receiving care and support. For example, using pictures and symbols when planning people's days.

People engaged in wide variety of activities and spent time in the local community going to specific places of interest. For example, shopping, cinema, swimming, meals out and various tourist attractions. This enabled their social and emotional needs to be met. One staff member commented: "(Person) is out for lunch today and he likes a sherry. All have one main lunch trip out a week." People were encouraged to

maintain relationships with their friends and family. For example, care plans documented the importance to people of seeing their family.

There were regular opportunities for people, and people that matter to them, to raise issues, concerns and compliments. This was through on-going discussions with them by staff on a regular basis and at key worker meetings. Relatives were also made aware of the complaints system. The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. The service had not received any complaints. However, the registered manager recognised that if they received a complaint, they would attend to it in line with the organisation's procedure.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in January 2017 the well-led question was rated as requires improvement. At this time, although there were some new systems in place to assess, monitor, and improve the quality and safety of care, the systems were not entirely effective. Not all issues identified during the inspection had been identified through the audit process. This inspection found improvements had been made. However, checks had failed to identify the issues around medicines management and the laundry cleanliness.

Checks were completed on a regular basis as part of monitoring the service provided. For example, the checks reviewed people's care plans and risk assessments, incidents and accidents and health and safety. This enabled any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. Where actions were needed, these had been followed up. For example, care plans reviewed and maintenance jobs completed. A representative of the provider regularly visited the service and the registered manager told us they felt well supported by them.

There was a new 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. The registered manager had quickly recognised on commencement of their post that the staff culture needed to be addressed to ensure people received person-centred care and support. They had addressed this through one to one and team meetings with staff. In addition, new staff had been recruited. The registered manager commented: "I feel there is a much more responsive team now."

An action plan had been developed by the registered manager. The action plan showed the actions which had already been completed. These included, up to date staff training and supervisions and care plans and risk assessments reviewed and updated. The organisation had also started to review the service's policies and procedures to ensure they were effective and reflected the practice at the service.

Staff spoke positively about communication and how the registered manager worked well with them, encouraged team working and an open culture. Staff said, "We are working much better as a team" and "(Registered manager) encourages us to be open about anything which is bothering us." Staff confirmed they were kept up to date with things affecting the overall service via team meetings and conversations on an on-going basis. Additional meetings took place on a regular basis as part of the service's handover system which occurred at each shift change.

People's views and suggestions were taken into account to improve the service. For example, link meetings had been introduced. This meant each person now had a dedicated staff team to drive up consistency of approach. This also enabled people's individual needs to be identified and actions taken. For example, re-decoration of a person's bedroom and purchasing a touch control tablet that would enable a person to use social media to contact their mum and dad. In addition, surveys had been completed by staff in January 2018. The surveys asked specific questions about the training and support they received. As a result, gaining

additional qualifications through an apprenticeship scheme was being introduced.

Surveys for people receiving the service were being developed in various user-friendly formats. These are due to go out in July 2018. The registered manager was also in regular contact with families, via phone calls and visits. Relatives commented: "We have a meeting at Tobias today for an update. The (registered manager) is very helpful" and "(Registered manager) is new. Lots of new ideas. She really does listen." The registered manager recognised the importance of ever improving the service to meet people's individual needs. This included the gathering of people's views to improve the quality and safety of the service and the care being provided.

People's equality, diversity and human rights were respected. The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value. Our inspection found that the organisation's philosophy was embedded in The Tobias Centre.

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP and psychiatrist. Regular medical reviews took place to ensure people's current and changing needs were being met.

The registered manager had notified CQC appropriately. We use this information to monitor the service and ensure they respond appropriately to keep people safe. The provider had displayed the rating of their previous inspection in the home, which is a legal requirement as part of their registration.

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 12 HSCA RA Regulations 2014 Safe care and treatment • Medicines management was not robust. • Infection control procedures were not entirely safe. Regulation 12 (2) (g) (h)