Care Network Solutions Limited

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

Summary of findings

Overall summary

The inspection of Clarence House took place on 8 November 2016. The inspection was unannounced. We previously inspected the service on 12 January 2015 and at that time we found the provider was not meeting the regulations relating to premises safety. On this inspection we checked and found some improvements had been made, however the registered provider was still not meeting the regulations related to premises safety.

Clarence House provides accommodation and personal care for up to 11 people who have a Learning Disability. The service is divided into two units for men and women.

The service is required to have a registered manager. 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 service had a registered manager.

Since our last inspection the registered provider has made a number of improvements to the cleanliness and maintenance of the home. However, during our inspection we saw evidence the registered provider had not ensured the safety and dignity of all people who used the service and building maintenance was still required. This was a continuing breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

People who used the service told us they felt safe at Clarence House. Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse. Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Effective recruitment and selection processes were in place and medicines were managed in a safe way for people.

There were enough staff to provide a good level of interaction, although some staff told us they worked long hours to cover for absence..
Staff had received an induction, supervision, appraisal and role specific training. This ensured they had the knowledge and skills to support the people who used the service.

People's capacity was considered when decisions needed to be made. This helped ensure people's rights were protected in line with legislation and guidance.

People were supported to eat a balanced diet and meals were planned alongside people.

Staff were caring and supported people in a way that maintained their dignity and privacy.

People were supported to be as independent as possible throughout their daily lives.

The service was led by each individual's goals and aspirations. Individual needs were assessed and met through the development of detailed personalised care plans and risk assessments, although one file we sampled contained contradictory information about medicines.

People and their representatives were involved in care planning and reviews. People's needs were reviewed as soon as their situation changed.

People engaged in social activities which were person centred. Care plans illustrated consideration of people's social life which included measures to protect them from social isolation.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

The culture of the organisation was open and transparent. The manager was visible in the service and knew the needs of the people who used the service.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on.
The registered provider did not provide formal supervision to enhance the professional development of the manager and support them in their role; however they completed regular monitoring visits and were available to provide advice on the telephone.

The registered provider had an overview of the service. They audited and monitored the service to ensure the needs of the people were met and that the service provided was to a high standard.

You can see what action we told the provider to take at the back of the full version of the 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

The service was not always safe

The building was not always maintained to promote people's safety and dignity.

Staff had a good understanding of safeguarding people from abuse and risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

There were enough staff on duty to meet people's individual needs and keep them safe and medicines were managed in a safe way for people.

Is the service effective?

Good

The service was effective.

Staff had received specialist training to enable them to provide support to the people who lived at Clarence House.

Capacity was considered when decisions needed to be made.

Meals were individually planned with people and people had access to external health professionals as the need arose

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported by the staff team in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and individualised.

People were supported to participate in activities both inside and outside of the service.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found the culture at the service to be positive, person-centred and empowering.

The registered manager was visible within the service.

The registered manager had an effective system in place to assess and monitor the quality of the service provided.

The registered provider did not provide professional supervision to the registered manager to support them in their role and did not ensure the building was always maintained in a safe way for people.

Clarence 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.

This inspection took place on 8 November 2016 and was unannounced. The inspection consisted of two adult social care inspectors and a specialist advisor with expertise in mental health and learning disabilities.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider and feedback from local authority safeguarding and commissioners. We had sent the provider a 'Provider Information Return' (PIR) form prior to the inspection, which the provider had returned. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time in the lounge area and dining room observing the care and support people received. We spoke with five people who used the service, one bank support worker, two senior support workers, two community professionals and the registered manager. Following the inspection we spoke with the operations manager. We looked in the bedrooms of five people who used the service. During our visit we spent time looking at five people's care and support records. We also looked at three records relating to staff recruitment, training records, maintenance records, and a selection of the services audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Clarence House. One person said, "Staff are always checking to make sure I am OK." We spoke with one person to ask if they felt safe when in town or going to college. They said, "Yes there is always staff with me." Another person told us, "I feel more safe here than where I was. You have staff around you all the time. You can talk to them."

We asked one person if they knew how to use the cleaning products safely, they said, "Yes. The staff go on and on about it all the time."

One person who used the service said when asked what could improve the service, "They should knock it all down and start again."

At our last inspection on 12 January 2015 we found the registered provider was not meeting the regulations relating to safety and suitability of premises because appropriate furniture had not been provided to meet one person's behavioural needs and broken glass had not been made safe in the person's bedroom which presented a risk of harm. At this inspection we checked and found some improvements had been made, however we found people who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises. For example in one person's bedroom the furniture was now fixed to the wall to prevent harm to people, however there was mould in the en-suite shower, damp damage to the ceiling and the extractor fan was filled with dirt. We found mould to the en-suite shower rooms in three people's bedrooms. This meant there was a risk of harm to people using the service because the registered provider had not ensured the building was safe, clean and suitable for its intended use.

Building maintenance was not always completed promptly to keep people who used the service safe and promote dignity and well-being. We found one person's bathroom door had not been replaced following a behavioural incident in October 2016, which meant their privacy and dignity was compromised. We saw from maintenance records this work had been requested in the maintenance book as "Urgent for dignity," on 19 October2016 by the registered manager and the door was replaced on the day of our inspection, three weeks later. In another person's room the bedroom window which overlooked a busy road had been painted with a coating for dignity as the person removed any window coverings that were used and the coating had been scratched off with no alternative provided for the person.

This demonstrated the registered provider had not ensured the premises protected people's safety and dignity. The above issues demonstrated a continuing breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As the registered provider had not been meeting this regulation at our previous two inspections we took action to require the registered provider to ensure the building was maintained in a timely manner and ensure it was well maintained, clean and suitable for people using the service.

The registered manager had a file which contained evidence of the service and maintenance work completed by external contractors and demonstrated they had requested maintenance work to be

completed in a timely manner.

We saw some building alterations had been made to reduce risks to people such as changing light fitting to reduce the risk of self-harm.

We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing (PAT). Checks had been completed on fire safety equipment and fire safety checks were completed in line with the registered provider's policy. This showed the registered manager had a system in place to protect people against the risks of unsafe or unsuitable equipment. A series of risk assessments were in place relating to health and safety of the building.

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One staff member said, "I would go to my manager, log the issue and report it to safeguarding and CQC. If it was the manager I would go above them." We saw information around the building about reporting abuse and whistleblowing.

We saw the service had managed many complex safeguarding situations and incidents had been dealt with appropriately when they arose to keep people safe and protect their rights. We saw all incidents had been notified to safeguarding authorities and CQC. This showed the registered manager was aware of their responsibility in relation to safeguarding the people they cared for.

Systems were in place to manage and reduce risks to people. One person using the service told us, "I am not allowed to use anything sharp. It's for safety." In people's care files we saw comprehensive risk assessments to mitigate risk when accessing the kitchen, behaviour that challenged, personal security, physical health, finances, decision making, locked doors and using public transport. We saw these assessments were reviewed regularly, signed and up to date. For example; One person who was living with epilepsy had a comprehensive risk assessment in place, which described risk mitigation measures such as motion sensors and specific instructions for the administration of medicines when seizures occurred. Scrutiny of staff training files showed all staff had undergone training in the use of the medicine. Our discussions with staff demonstrated they had a good understanding of their responsibilities and we were confident they were able to put their training into practice. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence.

One person told us, "I haven't got a key. It was taken off me for my own safety." We saw each person had signed an agreement about having a key to their bedroom and if they did not have a key the reason for this was documented in their care plan and risk assessment, although one of these documents was not readily available on the day of our inspection due to being archived. We discussed this with the registered manager and we saw from audits they were already planning to document any risks related to having a room key on the room key agreement itself. This showed the service had a risk management system in place which ensured risks were managed in the least restrictive way.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded in detail and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. All incidents were collated onto a monthly chart which enabled the manager and staff to monitor patterns of untoward behaviour and take action to modify care plans accordingly. Our

discussion with the manager demonstrated the importance they placed on reflective practice in caring for people. This demonstrated they were keeping an overview of the safety of the service.

The manager told us each person who used the service was allocated staff according to their assessed needs and we saw this was reflected in their care records and tallied with the number of staff on duty. We saw appropriate staffing levels on the day of our inspection which meant people's needs were met promptly and people received sufficient support.

Senior staff were on call at night in the event of an emergency. The provider had their own bank of staff to cover for absence and asked familiar staff to do extra shifts in the event of sickness. This meant people were normally supported and cared for by staff who knew them well.

Some staff told us they were working long hours and recruitment was on-going for permanent staff. Three staff slept in at night and sleeping accommodation was limited and cramped for staff. As there was only one sleep-in room containing bunk beds, if a male staff member was on duty at night they slept in the small office on a sofa which pulled out into a sofa bed, which meant they were likely to be working whilst tired the following day due to the cramped conditions, which could present a risk to staff and people using the service. The registered manager told us they had forwarded a plan to the registered provider for alterations to the building to improve the situation and this was being considered along with other options.

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people. For example, the provider ensured references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. The registered manager told us they did explore gaps in employment when conducting interviews with candidates and agreed to ensure this was recorded in future recruitment. This showed staff had been properly checked to make sure they were suitable and safe to work with people.

Appropriate arrangements were in place for the management of medicines. The manager told us all staff at the home completed training in safe administration of medicines every year and we saw certificates to confirm this. We saw from the records we sampled staff competence in medicines administration was assessed when they commenced administering medicines and had been recently assessed in response to a medicines error in order to improve staff practice and identify any learning needs. The service did not routinely assess competence annually as advised by the royal pharmaceutical society guidelines; however the registered manager was intending to introduce this system. This meant people received their medicines from people who had the appropriate knowledge and skills.

Staff we spoke with had a good understanding of the medicines they were administering and we saw medicines being administered as prescribed. People's medicines were stored safely in secure medicines cupboards.

Blister packs were used for most medicines at the home. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. Staff maintained records for medicines which were not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. We saw a stock check was completed daily and signed by two members of staff. This demonstrated the home had good medicines governance.

We saw the medicines were given safely and people were sensitively helped to take their medicines.

We saw mental capacity assessments had been conducted with regard to people's ability to safely administer their own medicines. Where people had capacity they had signed to consent to care staff administering their medicines. No people self-medicated.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded.

Medicines care plans contained detailed information about medicines and how the person liked to take them, including an individual 'as required' (PRN) medication protocol for the person. Having a PRN protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. This meant people were protected against the risks associated with medicines because the registered provider had appropriate arrangements in place to manage medicines.

People had a personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated in an emergency. A fire training sheet was signed by staff and fire drills occurred regularly. This showed us the home had plans in place in the event of an emergency situation.

Good

Is the service effective?

Our findings

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. We asked three staff what support new employees received. They told us they completed a two week induction program including training, going through all the care plans and shadowed a more experienced staff member before they were counted in the staffing numbers. The shadowing focused on getting to know people's individual needs and preferences. This demonstrated that new employees were supported in their role.

We looked at the training records for three staff members and saw training included infection prevention and control, first aid, food hygiene, autism awareness, mental health awareness and safeguarding adults. Staff told us and we saw from records they also completed specialist training in preventing and managing behaviour that challenges. We saw from the training matrix training was up to date and further training was planned onto the rota. Staff were also supported to complete nationally recognised qualifications in health and social care. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff we spoke with told us they felt appropriately supported by managers and they said they had supervision every three months, although records indicated this was every 6 months, an annual appraisal and regular staff meetings. Staff said, "I feel supported," and, "You do have a lot of support. I can ask if I am unsure." Staff supervisions covered areas of performance and also included the opportunity for staff to raise any concerns or ideas. This showed staff were receiving regular management supervision to monitor their performance and development needs.

The registered provider had policies in place in relation to the Mental Capacity Act 2005 (MCA). 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 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 registered manager was knowledgeable about the MCA and DoLS and knew the CQC needed to be notified when the outcome of any applications were known. We saw eight standard authorisations had been submitted to supervisory bodies for current residents, all of which had been granted. Two authorisations were in place with attached conditions. We saw care records translated the conditions into the care plan which were being met.

Staff at the service had completed training and had a good understanding of the Mental Capacity Act 2005. One staff member said, "We always involve people in every decision made."

We saw five people had an independent mental capacity advocate (IMCA) appointed to help people with decision making. We saw four of these people had chosen to exercise their rights to ask the courts under section 21A of Mental Capacity Act 2005 to review the authorisation. The registered manager had taken steps to ensure all relevant correspondence with the people concerned was filed in a specific section of the care records to allow ease of access for the IMCA. This meant the human rights of people who used the service were protected and they were not unlawfully deprived of their liberty.

We spoke with the registered manager regarding the service's approach to restraint measures. They told us the service used physical restraint only in the most serious of situations. We were told all staff undertook Management of Actual or Potential Aggression (MAPA) training which teaches management and intervention techniques to cope with escalating behaviour in a professional, legal and safe manner. Our scrutiny of staff training records showed this to be the case. We saw the training was underpinned by a comprehensive policy which defined the scope and methods of intervention. The definitions were made clear by the use of pictures to demonstrate safe holding techniques. We saw where physical aggression was a feature of people's mental ill-health a care plan incorporating least restrictive physical intervention techniques had been formulated based on an individual risk assessment incorporating warning signs, using appropriate risk assessment documentation.

Our discussion with the registered manager and our observation from care records showed a post incident care plan review took place, with people being offered the opportunity to contribute. We spoke with a carer regarding the use of restraint. They told us restraint should only be used as a last resort when all other alternatives have been used and it was considered the situation would escalate further if no intervention was made.

People at Clarence House told us they enjoyed their meals and could choose what they wanted. Each week a menu was planned for the week ahead in each of the two units and people took it in turns to help staff to make a meal each evening. Meals were planned around the tastes and preferences of people who used the service. People helped themselves to breakfast and lunch with support if required. Staff supported people to bake if they enjoyed baking and we heard one staff member offering to bake with people on the day of our inspection.

We heard staff offering a person who used the service a choice of meal and we saw they received the meal and drink of their choosing. One person told us, "We make our own dinners, they make evening meal. We help with tea. I made chicken and salad and mixed veg."

Each person had a list of food likes and dislikes in their care records, which was used to inform meal planning and a meeting was held every week on each floor to plan the menu. We saw some people helped themselves to a hot drink and food and drink was available to people throughout the day. A food communication book was used for people to feedback comments or suggestions about meals. We saw fruit was available to people throughout the day and healthy eating was encouraged, although one person told us they preferred to do their own shopping as the food provided was not healthy enough for them.

We saw the individual dietary requirements of people were catered for, for example; one person who used the service was supported to follow a gluten free diet. Meals were recorded in people's daily records. This included a record of all food consumed, including where food intake was declined and details of the food eaten. Some people were weighed weekly if needed to keep an overview of any changes in their weight. This

showed the registered provider ensured people's nutritional needs were monitored and action taken if required.

One person said, "I've just been to the dentist with staff." People had access to external health professionals as the need arose. The staff we spoke with were aware of the signs and symptoms of people's specific medical conditions and the action to take to ensure their well-being. Staff told us systems were in place to make sure people's healthcare needs were met and we saw from people's care records that a range of health professionals were involved. This had included GP's, psychiatrists, community nurses, chiropodists and dentists, consultants and psychologists. This showed people who used the service received additional support when required for meeting their care and treatment needs.

The atmosphere of Clarence House was comfortable and homely. There were pictures, craft work and photographs in the communal areas, which provided a homely and personalised environment for people.

Good

Is the service caring?

Our findings

People who used the service told us they liked the staff and we saw there were good relationships between people. One person told us, "The staff will do anything for me." And another said, "Staff notice if I am getting upset-they give me time to chill. They make sure we are OK, we can go and talk to them." One person said, "Staff are nice. People are nice. We get on."

Another person said, "The staff are all pretty good. I went to the staff yesterday. I got upset. They offered to talk to me so I don't bottle things up."

Staff we spoke with enjoyed working at Clarence House and supporting people who used the service. One staff member said, "I really enjoy working here. We have a good staff team that care."

We found staff had a good knowledge of people's individual needs, their preferences and their personalities and they used this knowledge to engage people in meaningful ways, for example chatting to them about hobbies or activities. Staff told us they spoke to the person, or their family members, about their likes or dislikes and spent time getting to know them during induction to the home. We saw care files contained detailed information about the tastes and preferences of people who used the service and staff told us they had opportunity to read these records before commencing work with the person. This gave staff a rounded picture of the person, their life and personal history.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We saw one person was reassured in a kind and supportive way when they requested some medicine as they were feeling ill. We saw staff talking with people about activities and interests and one staff member complementing a person's hair. One person was celebrating a special birthday on the day of our inspection and staff had decorated the room with surprise balloons and bought the person some gifts which they was delighted with, as well as arranging to go out in the evening for a birthday celebration meal.

People were supported to make choices and decisions about their daily lives. One person told us, "They offered me to take my own medicines, but I prefer them to give it to me." We saw from records people could choose their key workers. Staff used speech, gestures, objects and facial expressions to support people to make choices according to their communication needs. Care plans included information to support communication with people, for example for one person with limited verbal communication the care record said, "Understands basic instructions eg: put teabag in cup. Will sometimes state, "sad", but cannot explain why."

We saw where people lacked capacity to make certain decisions they had access to advocacy services. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights.

People's individual rooms were personalised to their taste and included personal items, photographs and

posters. Some people told us they chose their wall colour. Personalising bedrooms helps staff to get to know a person and helps to create a sense of familiarity and make a person feel more comfortable.

Staff were respectful of people's privacy; they knocked on people's doors and asked permission to enter. Staff told us they ensured doors were closed whilst supporting people with personal care and enabled them to complete their own support where possible to maintain dignity. One person told us staff could see them using the bathroom when they entered their bedroom, because their bathroom door had not been replaced. The manager told us this was on the list of maintenance tasks sent to the registered provider and was replaced on the day of our inspection.

One person who used the service said, "I have capacity so I manage my own money, but staff help me to budget." Another person said, "I do my own washing. I cook for all the (people) if it is my one to one." People were encouraged to do things for themselves in their daily life, such as washing, cleaning and shopping. We saw people were supported to safely help themselves to a hot drink and meal and maintain their independent living skills. Some people who used the service used the community independently and this control and independence was actively promoted by the service. This showed people were encouraged to maintain their independence.

Good

Is the service responsive?

Our findings

One person who used the service said, "I get up when I want and go out when I want. Most days we have the staff to take us out." Another said, "If I read my care plan it makes me agitated, but I can look at it with staff if I want to. We can ask if we want to see our care plan. They keep it confidential." Another person said, "We have review meetings. When staff have the file out they read what they have put to you and you sign the care plan. They do involve you."

Through speaking with people who used the service and staff we felt confident people's views were taken into account. We saw staff at Clarence House were responsive to people's needs, asking them questions about what they wanted to do and planning future activities. Staff were patient with people, and listened to their responses.

One staff member said, "I come to work for the clients. I love my job. When they achieve something I feel I have helped. When they move on and we have helped them."
We saw people had been involved in planning their support. Where this was not possible or not desired by the person their advocate, family and other relevant health and social care professionals had been involved. This meant the choices of people who used the service were respected.

The staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. We found care plans contained information about people's preferences, for example; "Likes curry and pizza." This helped care staff to know what was important to the people they supported and helped them take account of this information when delivering their support. Daily records were also kept detailing what activities the person had undertaken, what food had been eaten, as well as their mood and any incidents. This showed the service responded to the needs and preferences of people who used the service.

It was evident through discussions with staff that they spent time trying to understand each person and how best to meet their needs. Care plans were person centred and detailed and covered areas such as accessing the community, social skills, relationships, domestic activities, food and shopping, medication, decision making and money and included long term goals the person was working toward. For example, one person's care plan described the level of support they needed to keep their room tidy and clean. It described the prompts which would help the person to live as independently as possible.

Care plans also contained detailed information about people's individual behaviour management plans, including details of how staff would care for people when they exhibited behaviours that challenged, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. One staff member said, "We try to redirect, we don't like to use restraint. If they are carrying on, but there is no risk of harm we don't use it." This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

People's needs were reviewed as soon as their situation changed. The manager told us, and we saw from

records, reviews were held regularly and care plans were reviewed and updated monthly or when needs changed. These reviews helped monitor whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage.

We saw in one care file the record of medicines in the medicines care plan and the record in the hospital passport were not the same and two care plans were present, one of which was not dated. We addressed this with the senior on duty who told us the MAR charts and medicines would be taken to hospital with the person if they were admitted but they would ensure this inconsistency was addressed straight away.

One person said, "We go out all the time, bowling, trampolining. I've been to Blackpool twice." Another person said, "We sometimes go to Scarborough or Blackpool. We play football; go to the cinema, meals and concerts. I do work experience at a charity shop."

People told us they went to local pubs, cafés, shops, bowling and the cinema and on trips further afield. Staff spoke with good insight into people's personal interests and we saw from people's support plans they were given many opportunities to pursue hobbies and activities of their choice. People were supported to attend college or undertake voluntary work if they wished to do so. People told us they were enabled to see their families as often as desired. This meant staff supported people with their social needs.

People we spoke with told us staff were always approachable and they were able to raise any concerns. We saw there was an easy read complaints procedure on display and in people's care files including the contact details of the managing director of the company. Staff we spoke with said if a person wished to make a complaint they would facilitate this.

We saw the complaints record showed where people had raised concerns these were documented and responded to appropriately. Compliments were also recorded and available for staff to read.

Requires Improvement

Is the service well-led?

Our findings

One person who used the service said, "I see the manager every day. The manager is doing a pretty good job from what I have seen." Another person said, "It's good."
People told us the best thing about the service was, "Having conversations. Someone to go to with problems." Another person said it was, "The nice staff."

Two community professionals told us the person they supported had done really well at the service, the staff were good and managed people well.

The registered manager had worked at the service for around eight years and became registered manager in June 2014, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

Two senior support workers worked 40 hours a week and the management team were on call on a rota when they were not on duty.

Staff we spoke with were positive about the registered manager and told us the home was well led. They told us, "The manager is very approachable." and, "I'm happy. If I had any issues I can go the manager or the area manager."

The registered manager said the service aimed to support people to live an everyday life, to be as independent as possible and to achieve their own aims and objectives. They also wanted to ensure staff felt supported and they were available at all times for staff. The registered manager told us they attended managers' meetings and training to keep up to date with good practice. This meant they were open to new ideas and keen to learn from others to ensure the best possible outcomes for people using the service.

The registered manager told us they were able to contact a senior manager at any time for support; however we saw they did not receive professional supervision or appraisal from the registered provider to ensure their professional development needs were met. We spoke to the area manager about this and they told us they would introduce written supervision along with their monthly audit visits to the service, which already included management support and development, but this had not been recorded.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on. House meetings were held on a monthly basis in each unit and topics discussed included activities, work placements, damage to property and what people wanted to do for Christmas. Some people had requested more art and craft activities and games and this was facilitated.

Anonymous questionnaires were sent out to family members every six months by the registered provider, however only one relative had returned a questionnaire since our last inspection.

The registered manager recorded feedback discussions with people and staff about the quality of the

service and a regular staff survey was completed. We saw action had been taken where issues were raised.

Staff meetings were held approximately every month. Where staff meetings were held to impart information to teams, praise was given and recorded as well as areas to improve. Topics discussed included handover records, sickness policy, staff training, individual resident's needs, and health and safety. Actions from the last meeting were discussed and goals were set from the meeting. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

We saw audits were maintained in relation to premises and equipment. There was evidence of internal daily, weekly and monthly quality audits and actions identified showed who was responsible and by which date. Audits of medicines, health and safety and service users' money were conducted. Care plans and documents were also reviewed and audited frequently. The manager completed random spot checks on staff practice on their weekly walk round and the management team also observed staff competence in various areas of practice such as administration of medicines. Daily handover records were used to ensure tasks such as cleaning were completed and these were checked and signed by senior staff. We saw on 24 and 26 October 2016 these records had not been signed as checked by senior staff and the registered manager told us they would address this with them. This showed staff compliance with the registered provider's procedures was monitored.

Information was passed to the registered provider by the registered manager every week regarding incidents, complaints, supervision, health and safety and other issues. The operations manager visited the home every month to complete audits and ensure compliance with the registered provider's policies and procedures. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation, however they had not always acted in a timely manner to ensure the premises was safe and suitable for the people who used it.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There was a risk of harm to people using the service because the registered provider failed to ensure the premises was clean, suitable for its intended use and properly maintained.

The enforcement action we took:

Issued warning notice to comply by 31 January 2017