Care Quality Commission

Milewood Healthcare Ltd

Holgate House

Inspection report

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21 June 2016

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**

Summary of findings

Overall summary

The inspection took place on the 20 and 21 June 2016. The inspection was unannounced. At our previous inspection of the service on the 03 and 08 February 2016, we identified nine breaches of the legal regulations set out under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Five of the identified breaches included Regulation 11(Need for consent), Regulation 14 (Meeting nutritional and hydration needs), Regulation 15 (Premises and equipment), Regulation 17 (Good governance) and Regulation 18 (Staffing). These breaches were assessed as having a low service impact and we dealt with these by issuing a requirement for improvement notice to the registered provider. The registered provider sent us an action plan that contained information on how they intended to meet with those regulations and compliance with these regulations will be inspected at our next comprehensive inspection.

The four remaining breaches were assessed as having a moderate service impact and we dealt with these by issuing the registered provider with a written Warning Notice for improvement for each breach. The breaches we dealt with in this way were Regulation 9 (Person centred care), Regulation 10 (Dignity and respect), Regulation 12 (Safe care and treatment) and Regulation 13 (Safeguarding service users from abuse and improper treatment). This inspection was planned to focus on whether improvements had been made by the registered provider to rectify the four breaches dealt with by way of written Warning Notices only.

This report covers our findings in relation to the Warning Notices. You can read the report from our last comprehensive inspection by selecting the 'All information' and searching for Holgate House on our website at www.cqc.org.uk.

Holgate House is a care home service without nursing. The service provides accommodation for up to 30 older people and younger adults with varying needs that include care and support for learning disabilities, autistic spectrum disorder and/or mental health. At the time of our inspection there were 19 people receiving a service. Holgate House is located in the historic city of York with good public transport links. Off road parking is available at the rear of the building for visitors.

Holgate House did not have a registered manager. The registered manager submitted an application to cancel their registration to manage all regulated activities and have their registration removed on 15 January 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our inspection, we were supported by the nominated individual and the commercial director who were running the service.

We saw that all care workers had now received up to date safeguarding training. The registered provider had a policy and procedure in place for safeguarding vulnerable adults. Care workers were aware of types of abuse to look out for and knew how to report their concerns. People told us they felt safe. This meant

people were being protected from abuse and improper treatment. We saw these changes resulted in the registered provider meeting the breach of regulation, previously identified in the Warning Notice for Regulation 13 Safeguarding service users from abuse and improper treatment, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes for risk assessments, prevention of risk and awareness of risk were found to have been updated. Risk assessments had been completed for people and we saw these were documented and reviewed in people's care plans. We saw care plans included information to help people evacuate the service in the case of an emergency. Fire checks were robust and care workers had received appropriate training in fire awareness. Security around the service had been improved and we saw appropriate risk assessments documented for the service and the environment. We saw these changes resulted in the registered provider meeting the breaches of Regulations, previously identified in the Warning Notices for Regulation 12 Safe care and treatment, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that all care workers who administered medicines had completed refresher medicines training. Medication audits were carried out with resulting actions documented. We observed medicines were handled appropriately by care workers. People received their medicine at the correct time of day and this was signed by the two care workers who administered the medicines. Medicines including controlled drugs were safely and correctly stored. Other health professionals told us that the management of medications had improved and we saw this was the case from the reduction in notifications for medication errors we had received since our last inspection. We saw these changes resulted in the registered provider meeting the breaches of Regulations, previously identified in the Warning Notices for Regulation 12 Safe care and treatment, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the medication policy did not reflect current practice at the service. The registered provider agreed to review and update this policy. This was part of an on-going breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are monitoring the breach of Regulation 17 separately and this will be reviewed as part of our follow up inspection.

All care workers had completed training in 'Management of Actual or Potential Aggression (MAPA)'. This meant care workers had received training at a suitable level to make sure any control, restraint or restrictive practices were only used when necessary. Care plans had been reviewed and where appropriate updated with an individual behaviour management support plan and risk assessments. Where the registered provider had concerns about an individual's capacity to make informed decisions they had included referrals to other health professionals and care workers had received training in and had a basic understanding of the requirements of the Mental Capacity Act 2005 (MCA). We saw these changes resulted in the registered provider meeting the breaches of Regulations, previously identified in the Warning Notices for Regulation 13 Safeguarding service users from abuse and improper treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people were supported with their personal care. Care plans we reviewed contained personal hygiene risk assessments and monitoring records. People were addressed and spoken with in line with their preferences by care workers who understood their needs. This meant people were treated with dignity and respect by care workers and others around the home. We saw these changes resulted in the registered provider meeting the breaches of Regulations, previously identified in the Warning Notices for Regulation 10 Dignity and Respect, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained information about people's health needs and contact details of health and social care

professionals involved in supporting the individual. This meant there were systems in place to ensure that people were supported to access healthcare services where necessary.

People were involved in the planning of their support and care. We saw that where the person was able to sign their consent to the planned care and support this had been included. This meant the information was reflective of people's current needs. We saw these changes resulted in the registered provider meeting the breach of Regulations, previously identified in the Warning Notice for Regulation 9 Person centred care, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had completed and signed to agree to a 'Smokers agreement'. Care plans included a smoking risk assessment and information on how to support the individual. We observed people were no longer smoking in communal areas and we saw care plans contained signed smoking agreements and documented discussions regarding enforcement. This meant the registered provider had appropriate measures in place to minimise the risks associated with people smoking in the home and in their rooms and we saw this work was on-going. We saw these changes resulted in the registered provider meeting the breach of Regulation, previously identified in the Warning Notices for Regulation 13 Safeguarding service users from abuse and improper treatment, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans we looked at centred on the person and included details on how to support people with daily living. People had a documented named key worker and a list of people involved in their care. We observed care workers spending one-to-one time with people and a range of activities that included days out, trips and holidays had been implemented and were supported. This meant that the registered provider had taken steps to ensure sufficient care workers were available to meet people's individual needs and that these were documented and reviewed with people. People were not left in avoidable isolation and were receiving person centred care and support in line with their preferences. We saw these changes resulted in the registered provider meeting the breaches of Regulations, previously identified in the Warning Notices for Regulation 9 Person-centred care under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw during this inspection, that people's care files included a 'Hospital Passport'. This included appropriate personal information that included any health, medication, mobility or other information that a hospital or other health professional would need to know when a person was admitted from the service to help them to receive appropriate treatment. We saw these changes resulted in the registered provider meeting the breaches of Regulations, previously identified in the Warning Notices for Regulation 12 Safe care and treatment, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was safe.

People told us they felt safe and we saw care workers had received training in safeguarding adults and understood the types of abuse to look out for and how to report their concerns.

The registered provider acknowledged and mitigated known risks for people, the service and the environment and we saw documented risk assessments had been implemented and updated.

Management of medication had improved, care workers responsible for medication had received appropriate training and errors of management of medication had reduced.

This meant that the provider was now meeting legal requirements.

While improvements had been made, we have not revised the rating for this key question; to improve the rating would require a longer-term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Is the service effective?

Inspected but not rated

The service was effective.

The service adhered to regulations under the Mental Capacity Act 2008 and care workers had received appropriate training.

People who lacked capacity had applications for reviews by the local authority in place.

Care workers understood and had received training in the appropriate use of restraint where people showed signs of challenging behaviour.

This meant that the provider was now meeting legal requirements.

While improvements had been made, we have not revised the

rating for this key question; to improve the rating would require a longer-term track record of consistent good practice. We will review our rating for effective at the next comprehensive inspection.

Is the service caring?

Inspected but not rated

The service was caring.

Care and support people received had improved and care plans focused on the person.

Care workers treated people who used the service with dignity, consideration and respect.

This meant that the provider was now meeting legal requirements.

While improvements had been made, we have not revised the rating for this key question; to improve the rating would require a longer-term track record of consistent good practice. We will review our rating for caring at the next comprehensive inspection.

Is the service responsive?

Inspected but not rated

The service was responsive.

Care plans had been updated and reviews were implemented monthly or as people's needs changed.

A schedule of individual and group activities for people had been introduced for people.

People told us they were involved with and we saw they had signed to agree to their care and support planning.

This meant that the provider was now meeting legal requirements.

While improvements had been made, we have not revised the rating for this key question; to improve the rating would require a longer-term track record of consistent good practice. We will review our rating for responsive at the next comprehensive inspection.

CareQuality Commission

Holgate 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over two days on 20 and 21 June 2016 and was unannounced. On the 20 June, the inspection was carried out by two people; one adult social care inspection manager and one inspector. On the 21 June, the same team completed the visit with two pharmacy inspectors in attendance.

Prior to the inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned services from the registered provider.

The registered provider submitted a provider information return (PIR) prior to the inspection. 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.

During the inspection, we spoke with four people who resided at the home, three care workers, one senior employee and the Nominated Individual (NI). We also spoke with an agency domestic staff member, a health visitor and after the inspection we contacted the local GP practice to seek their feedback. We looked at records that related to people's individual care, this included the care planning documentation for five people and other care related records.

We looked at the recruitment and training records for four care workers, the care workers rota, records of audits, policies and procedures and records of meetings. We observed the way care workers interacted with people and undertook an observation of the mid-day medication round and lunchtime snack in the dining room. We looked at a number of other records including medication assessment records, fire safety records, and other audits of how the service was operating. We looked at the overall environment and how well the service was maintained. This included all parts of the home and included people's bedrooms (with their permission).

Inspected but not rated

Is the service safe?

Our findings

During our previous inspection on 03 and 08 February 2016, we found that people were not always kept safe from abuse and improper treatment. Care workers had not all received training in safeguarding adults and some care workers we questioned, were unable to identify types of abuse to look out for when providing care and support to people. We issued the registered provider with a Warning Notice to meet with the breach identified under Regulation 13 Safeguarding service users from abuse and improper treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we saw that all care workers had now received up to date safeguarding training. A care worker told us, "I am up to date with all my training including safeguarding," "I know types of abuse to look out for, for example financial, mental, physical, psychological, neglect and I would report any concerns straight away." They told us, "I am confident all concerns would be addressed" and "People living here are a lot safer than they used to be." A person receiving a service told us they had suffered some financial abuse. They told us they had reported it to a care worker and appropriate action was taken. They said, "I don't think I would have reported it before but it's better here now than it used to be and things are getting sorted out." This meant people were being protected from abuse and improper treatment. We saw these changes resulted in the registered provider meeting the breach of Regulation, previously identified in the Warning Notice for Regulation 13 Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection, we saw that risk assessments were incomplete and inconsistent with care plans and other paperwork. Systems and processes for risk assessments, prevention of risk and awareness of risk were found to be inadequate. We issued the registered provider with a Warning Notice to meet with the breach identified under Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from people's care plans that they contained documented information on individual risks that included financial abuse, missing person information, personal hygiene, mental health, fire, smoking, medication, and use of the kitchen areas. Additional risk assessments were in place for nutrition, self-harm and alcohol misuse.

Care plans we looked at included additional information to keep people safe. This included 'Generic Infringement of Rights' forms completed, where for example, access to hazardous substances was restricted and 'Specific Infringement of Rights' forms completed, where for example, people's access to sharps or through a locked door was restricted. We saw these forms detailed the risk associated with the activity and the impact on the person should the infringement be removed. These had been reviewed with the individuals concerned and where appropriate people had signed their agreement. This meant up to date information was available to care workers to provide care and support safely.

The registered provider had an up to date fire certificate. The NI showed us a 'Fire File'. This contained monthly-recorded fire drills, Fire Marshall training for three care workers and fire training for all other care

workers. A care worker confirmed, "We have all received training in case of a fire and we have Fire Marshalls who oversee the drills."

Care plans contained Personal Emergency Evacuation Plans (PEEP) for people. We saw PEEP's contained appropriate information on any assistance required by the individual to evacuate the premises in the case of an emergency. All care workers understood the importance of these documents, a care worker said, "All files have a PEEP so we know who needs assistance in the case of an emergency such as a fire so we can evacuate them in a safe and controlled manner."

The registered provider told us on the registered provider information return [PIR] "We have a locked door policy to keep strangers out." The registered provider had undertaken a premises risk assessment. Access into and between areas of the service was restricted to visitors by the use of key codes. We saw people living at the service used these codes and had free access to move around.

We were unable to use the front door due to the renovations but we were advised that this would be the main access point once renovations had been completed. We were met by senior care workers who provided us with access where we were required to complete a visitor book to record our visit to the service.

We observed, where windows opened, that window restrictors were in place to prevent people falling out. Weekly checks were documented to ensure these remained effective and kept people safe. Other safety checks included the electrical wiring. The NI told us this had been completed and they were waiting final certification of the changes. Portable Appliance Testing (PAT) had been completed and we saw gas installations and Control of Substances Hazardous to Health (COSHH) data sheets were up to date. This meant that environmental checks were in place to ensure access to the service and equipment in the service was safe for people to use.

The registered provider had a Health and Safety (H&S) policy in place and this was dated June 2015. However, this was a general policy and not specific to the service. Other policies we looked at included Legionella and Infection Control. We noted these also required updating and reviewing by the registered provider. We spoke with the NI about this. They advised us that reviews of these documents was scheduled to be undertaken. They showed us additional checks they were undertaking that included an infection control checklist. We saw these were completed weekly and a H&S risk assessment with associated actions had been completed to document and address any concerns and to help the registered provider to mitigate associated risks of the spread of infections.

At our previous inspection, we found that medication was not managed in a safe way for people. We found care workers had a lack of medication training and awareness. Medication was not administered in a timely manner in line with people's requirements, we saw that recording and control of medication was ineffective. We issued the registered provider with a Warning Notice to meet with the associated breach identified under Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities).

During this inspection, we found that all care workers who administered medicines had completed refresher medicines training. The NI was carrying out competency assessments for those care workers who did not administer medicines to help ensure they were competent before being signed off. We looked at the medication policy and saw that this did not reflect current practice at Holgate House. We asked the NI about this during the inspection who advised us the policy was due for review.

Medication audits were carried out twice weekly by a nominated individual and an additional comprehensive audit was undertaken monthly. We saw resulting actions were documented and these had

been completed. However, we saw actions documented on the twice-weekly audit for May were not documented in the May monthly audit. This was brought to the attention of the NI during our inspection. Where care workers had not followed the policy we saw action had been taken by the registered provider that included the person being removed from the process until they were re-observed and deemed competent.

During our inspection, we observed a medication round. We found that care workers had a good knowledge of people's preferences and were caring and compassionate during the medicines round. Medicines were handled appropriately by care workers. Individual medicines were stored in each person's room. Stock sheets were used for medicines not in Dosette boxes and this was appropriately managed. Medicines were administered by two care workers and dual signatures were recorded. A daily medicines task sheet had been developed to ensure each person received their medicine at the correct time of day and this was signed by the two carers who administered the medicines. Room temperatures were recorded on a daily basis for most people. Medicines including controlled drugs were safely and correctly stored. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Fridge temperatures were recorded daily. However, maximum and minimum temperatures were not recorded. This was brought to the attention of the NI during our inspection.

We looked at medication information documented in care plans for five people. We found that some care plans showed a lack of consistency and detail. Changes were not always updated in a timely manner. For example, one care plan stated an 'as required' (PRN) medicine was prescribed for anxiety. However, we saw this was not shown on the Medication Administration Record (MAR) and was not part of the person's behaviour management plan. Further checks showed that the medicine was no longer prescribed or available. We saw the same person's care file documented the person took Lansoprazole, however their MAR sheet documented this as Omeprazole. A second person's medication list was not dated and they had a PRN medication procedure record for a medicine that was not listed on their repeat medication list. This medicine was not available to administer should it be required. We looked at another care plan that stated the person was a diabetic however, their medicine had been reviewed and stopped but the care plan did not document this change. We asked the NI about this and they told us this would be picked up as part of the medication audit and review process.

We looked at one care record for a service user who was self-medicating and found that risk assessments had been completed and reviewed. Homely medicines, which are used to treat minor ailments, were recorded in care records however this was not signed by the GP for two of the five records in accordance to what was written in their policy. We spoke with the NI about our concerns and they told us that all care files were being updated and records for people would be amended to ensure all care workers had access to up to date information to ensure medication continued to be administered in a safe way. They told us these measures had already showed an improvement. The local authority told us, "There have been on-going issues with medication, and medication errors, although these seem to have reduced in the past few months as we know management have been working to reduce this." We looked at notifications submitted by the registered provider to the Care Quality Commission (CQC) for medication omissions and errors. We saw these had reduced in number and frequency since our last inspection.

A GP we contacted after the inspection told us, "I've noticed an improvement since the last CQC visit. On the couple of occasions I have reviewed patients, care workers seem more knowledgeable about the current presenting problem. They seem to be appropriately asking for medical advice, and although it may be a different care workers following up, they have confirmed they knew of the previous management plan." People we spoke with at the service did not raise concerns about the way their medication was managed

and told us that they received the correct medication at the correct time.

We saw improvements in the way medication was managed and we evidenced the registered provider had met with our requirements of the Warning Notice to meet with the breach identified in Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we concluded that the medication policy needed updating as it did not reflect current practice at the service. This was part of an on-going breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are monitoring the Breach of Regulation 17 separately and this will be reviewed as part of our follow up inspection.

Inspected but not rated

Is the service effective?

Our findings

During our previous inspection on 03 and 08 February 2016, we found the registered provider failed to protect people using the service from improper treatment whilst receiving care and support. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act (MCA). We issued the registered provider with a Warning Notice to meet with the breach identified under Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, care workers we spoke with told us how challenging behaviour shown by people at our previous inspection had reduced. They told us some people had moved out of the service and this had reduced some personality conflicts. They told us and we saw all care workers had completed training in Management of Actual or Potential Aggression (MAPA). This helped care workers deal with challenging behaviour, including aggression, in a calm way to help keep everyone safe. A care worker said, "The training was really good." They said, "I feel able to diffuse difficult situations and I now understand when proportional restraint can be used to keep people and others safe, for example I am able to link arms with one person when we are out in the community; this stops them running into traffic and enables them to get out more often." This meant care workers had received training at a suitable level to make sure any control, restraint or restrictive practices were only used when necessary.

Where people, care workers and others were at risk from challenging behaviour from people we saw that the associated triggers and risks were documented. This included information for care workers on de-escalation techniques and where appropriate physical interventions. An individual behaviour management support plan was in place that detailed 'What to do' as a preventative and reactive action and 'What not to do' to help people and others remain safe from harm. We saw information documented was in line with policy and procedures that were in place and that it was reviewed and evaluated monthly. Behaviour monitoring forms were in place however, we did not see where these had been evaluated. We asked a care worker about this and they told us, "The behaviour evaluation forms are a new addition to the care plans and will be included with the monthly evaluation." They continued, "The evaluation will enable us to monitor the number of incidents by the person and this will help us to identify a reduction or an increase." They continued, "We will be able to use this information to shape the techniques used and to focus on a reduction of incidents by the person."

Care workers had received training in and had a basic understanding of the requirements of the Mental Capacity Act 2005 (MCA). The 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 home services 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. We asked for details of people with a DoLS. The commercial director told us three people had a DoLS in place. We looked at those files and we observed that some of the authorisations had expired. We saw the registered provider had submitted new assessment applications to the local authority. They told us that they had contacted the local authority to request this information and were still waiting for a response. We saw that whilst these applications were being processed the registered provider had undertaken documented monthly reviews and risk assessments and that support plans had been updated. Reviews had included the Community Mental Health Team, Psychiatrists, GP's, and other health professionals. We saw where people lacked capacity the registered provider had contacted Advocacy services to support people to understand and make informed decisions in line with their rights. This helped to make sure decisions were made in people's best interest and that they were the least restrictive options.

During this inspection, we checked care plans and saw where people agreed they had signed consent to the storage of personal monies. This meant the registered provider had taken the appropriate steps to ensure decisions were made with a person's consent and that appropriate capacity and decision-making procedures had been followed.

We found that the registered provider was meeting the breach of regulation previously identified in the Warning Notice for Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service caring?

Our findings

During our previous inspection on 03 and 08 February 2016, we observed people in the service were not supported with their personal care, and care workers did not always treat people with dignity, consideration and respect. We issued the registered provider with a Warning Notice to meet with the breach identified under Regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we observed an improvement in the way people presented themselves. A care worker told us, "We are improving the environment for everybody and people are taking better care with their personal appearance but it can be a slow process for some; we have to be patient." They continued, "Some people have bought new clothes and we have a hairdresser who now attends once a month." A person in the service told us, "I have had my nails done recently and when the hairdresser comes, I tell her what I want done."

Care plans we reviewed contained personal hygiene risk assessments and monitoring records. These were completed by care workers who told us, "We recognise people have the right of choice with regards to their personal care and some people do choose to self-neglect; we fill in a record so we can work with people to encourage them to maintain their personal hygiene." Records detailed when care workers had prompted an individual, the time, the type of personal care undertaken and we saw these were signed by the care worker and reviewed to help shape their support plan. The NI showed us the laundry room that had been renovated. We saw people had individual laundry baskets and the registered provider had installed four new washing machines and three tumble dryers. This meant the registered provider had introduced measures to support people with their personal care.

People were addressed and spoken with in line with their preferences, in a patient manner by care workers who understood their needs. A GP we asked told us, "They [care workers] have been courteous with the patient [person] and escorted them into their rooms for me to examine them." During the medication round, we observed people received their medication in the privacy of their rooms and care workers spoke with people who understood their medication. We saw care workers knocked and waited for consent from the person before entering a person's room. One person who had poor hearing had a door sensor fitted. This activated a light so the person knew when care workers had entered their room. We saw they responded to this by signalling their consent or not to the care workers entering. This meant people were treated with dignity and respect by care workers and others around the service. We saw these changes resulted in the registered provider meeting the breach of regulation, previously identified in the Warning Notice for Regulation 10 Dignity and Respect, of the Health and Social Care Act 2008.

During our previous inspection, we found people were not always included in the decisions about their care; their care plans were out of date and did not reflect their current needs. We issued the registered provider with a Warning Notice to meet with the breach identified under Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, the registered provider told us on their PIR 'Care plans, risk assessments, pathway plans are reviewed and up to date.' During this inspection, the NI told us that reviews of care plans were progressing; they told us that six people had received reviews during April 2016 and one in May 2016 and all care files had been updated. Staffing had increased at the service and care workers told us, "We are still getting to know and understand people's needs, we are working with them and we are recording outcomes from the care we deliver." They told us they were using this information and involving individuals to ensure their care plans were reflective of their individual needs.

Care plans contained information about people's health needs and contact details of health and social care professionals involved in supporting the individual. We saw evidence that appropriate medical attention was sought, for example, following accidents or incidents; whilst one care worker told us "If you know people you can tell when they are unwell" and explained how they contacted people's G.P or family if needed. This showed us that there were systems in place to ensure that people were supported to access healthcare services where necessary.

The registered provider told us on the PIR "People are encouraged to have input into their care plans." We saw that where the person was able to sign their consent to the planned care and support this had been included. However, we saw that some people had only signed some areas of their care plan. One care plan contained the information, 'I do not want to read or sign my care plan' and this was dated with the review date. We spoke with a care worker about this. They told us, "We do try and involve people at all times with their care planning but sometimes they do not want to engage so we have try again to ensure they understand and agree to the information before signing; it's work in progress." Feedback from people we spoke with in the service included, "I have been involved with discussions around my care and this is written in my care plan" and "The care workers involve me in planning my care and they ask me for my opinion" and "They [care workers] ask me for my input but its fine as it is." During this inspection, we found that documented care planning had been reviewed for some people and updated for others. This meant the information was reflective of people's current needs. We saw these changes resulted in the registered provider meeting the breach of regulation, previously identified in the Warning Notice for Regulation 9 Person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection, we found that although the service had a zero smoking policy in place, people continued to smoke in their rooms and in the communal areas. There were no details in people's care plans of how they were supported with smoking or any documented involvement of other health professionals to mitigate the associated risks to the person or others living and working in the service. This meant the environment was not healthy for people and others and people's care was not being effectively managed to keep people safe and well. We issued the registered provider with a Warning Notice to meet with the breach identified under Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we saw people had completed and signed a 'Smokers agreement'. Care plans included a smoking risk assessment and information on how to support the individual. A care worker told us, "[Person] keeps smoking, their nurse visits weekly but progress is slow," they continued, "[Person] has purchased an e-cigarette to use in their room and they no longer smoked in communal areas." We looked around the service and where people provided permission, we looked inside their personal rooms. We saw that cleanliness had improved but we noticed two rooms still smelt of cigarettes. We spoke with NI about this. They told us, "People have been allowed to smoke in and around the service, including their own personal rooms for many years." They continued, "We have brought in the fire brigade to raise awareness of the risks of smoking in rooms," "We have involved other health professionals to encourage smoking cessation and we have built a smoking shelter outside to help enforce our no smoking policy." We observed people were no longer

smoking in communal areas and we saw care plans contained signed smoking agreements and documented discussions regarding enforcement. This meant the registered provider had appropriate measures in place to minimise the risks associated with people smoking in the home and in their rooms and we saw this work was on-going. We saw these changes resulted in the registered provider meeting the breach of Regulation, previously identified in the Warning Notice for Regulation 13 Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service responsive?

Our findings

During our previous inspection on 03 and 08 February 2016, we saw some people living in the home were left in avoidable isolation and were not receiving person centred care and support in line with their preferences. We issued the registered provider with a Warning Notice to meet with the breach identified under Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we looked at a selection of care plans for people residing in the home. We saw improvements had been made. Care plans we looked at had been updated with at least quarterly and sometimes monthly reviews in place. The NI told us this work was on going. We saw information was centred on the person and included details on how to support people with communication, social skills, personal relationships, leisure and social activities, daily living skills, personal care, material goods, spiritual and cultural needs, personal choice, mobility, finance and independent living skills. People had a documented named key worker and a list of people involved in their care. We saw care plans included a communication and visit record. In a care plan, we looked at this included communication, visits and updates with the person's family, health worker and their doctor.

We observed care workers spending one-to-one time with people. They undertook individual activities, held routine conversation and assisted people with their daily living skills. People were supported to make their own decisions and to live independently. A care worker told us, "[Person] can choose their own clothes; we provide them with assistance but encourage them to dress themselves." A person told us, "The service has bought me a wheelchair; it's great as it has enabled me to go out to the shops and to church and to do the things I enjoy." They continued, "A taxi will pick me up, care workers arrange the times and make sure I am ready at the right time." A care worker told us, "The registered provider is buying a vehicle to enable people to get out on more trips and access the community."

People were supported with their choices and decisions when purchasing material goods and activities that they liked were discussed and recorded. Other activities included group trips to the seaside. We observed people moving around the communal areas. We saw they engaged positively with other people living in the home and that they were supported by care workers during other times. A person told us, "I like living here, I have had my nails done, I have been shopping for new clothes and I enjoy colouring and completing jigsaws." A care worker told us, "The increase in care workers has enabled people to have the one-to-one support that they need which has already shown an improvement in people's lives." This meant that the registered provider had taken steps to ensure sufficient care workers were available to meet people's individual needs and that these were documented and reviewed with people. People were not left in avoidable isolation and were receiving person centred care and support in line with their preferences. This meant the registered provider had met with the identified breach of Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in the Warning Notice previously in place.

During our previous inspection, we found that ineffective procedures were in place for people to transition between services. We issued the registered provider with a Warning Notice to meet with the breach

identified under Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw during this inspection, that people's care files included a 'Hospital Passport'. This included appropriate personal information that included any health, medication, mobility or other information that a hospital or other health professional would need to know when a person was admitted from the service to help them to receive appropriate treatment. This meant the registered provider had met with the identified breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in the Warning Notice previously in place.