

Potensial Limited

The Barn

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The Barn is a care home providing accommodation for up to 12 adults who have learning disabilities and who need assistance with personal care. It is situated in a residential area of Leyland, close to the town centre and all local amenities. It is easily accessible by car or public transport. On road parking is permitted. All bedrooms are of single occupancy. The home is domestic in character providing comfortable accommodation for the people who live there. There is an enclosed garden area to the rear of the building.

The last inspection of this location was conducted on 17 March 2015. The overall rating at that time was 'requires improvement', with five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 being identified. Three of the breaches were in relation to safe care and treatment; the other two were around the need for consent and good governance. We asked the provider to tell us what they were going to do in order to address the shortfalls identified. The provider submitted an action plan, as requested.

This inspection was conducted on 14 February 2017 and it was unannounced, which meant that people did not know we were going to visit the home.

The registered manager was on duty at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated regulations about how the service is run.

At this inspection we found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to the need for consent and safe care and treatment.

At our last inspection on 17 March 2015 we found that people who used the service were not protected against the risks associated with the unsafe use and management of medicines, because appropriate arrangements had not been made for the obtaining, recording, using and safe administrations of medicines. Therefore, this area was in need of improvement. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 30 June 2015.

During the course of this inspection we assessed the management of medicines. We found that on this occasion improvements had been made in this area, which helped to protect people from any risks associated with the unsafe use of medicines. Therefore, the previous breach of the Health and Social Care Act regulations had been met. However, we found that hand written entries on the medicine administration records (MAR) had not always been countersigned by another person to reduce the possibility of errors. We have made a recommendation that all hand written entries are signed by two members of staff to ensure accuracy.

At our last inspection on 17 March 2015 we found that proper steps had not always been taken to ensure

people were protected against the risks of receiving inappropriate or unsafe care or treatment. This was because risks relating to their health, welfare and safety had not always been well managed. Therefore, this area was in need of improvement. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 31 July 2015.

At this inspection we found that robust risk assessments had been implemented in relation to health, welfare and safety. Environmental risk assessments had also been introduced. This helped to keep people safe. Therefore, the previous breach of the Health and Social Care Act regulations had been met.

At our last inspection on 17 March 2015 we found that people who used the service and others were not always protected against the risk of acquiring an infection, because infection control protocols were not consistently being followed. Therefore, this area was in need of improvement. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 8 May 2015.

At this inspection we found that the cleanliness of the premises had improved. It was realised that because of the age of the fixtures and fittings the environment was difficult to maintain to a good standard of cleanliness. We recognised the effort which had been taken to make the improvements. Therefore, the previous breach of the Health and Social Care Act regulations had been met. However, we found that infection control practices were not always promoted, in relation to health. One person was receiving treatment for scabies, but they were seen entering the laundry and were also seen lying on other people's beds. This meant there was a potential risk of cross infection whilst treatment was being received. Therefore, this was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 17 March 2015 we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person had not acted in accordance with the Mental Capacity Act 2005. The provider had not taken appropriate steps where people had been deprived of their liberty for safeguarding (DoLS) to have the authorised restrictions in place reviewed. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 18 May 2015.

At this inspection we found that DoLS authorisations had been followed up, which meant that the previous breach of Regulation 13 had been met. However, on this occasion, we found that Mental Capacity Assessments had not always been conducted, in order to determine capacity levels, prior to important specific decisions being made and Deprivation of Liberty Safeguard applications being submitted. Also evidence was not always available to demonstrate that decisions had been made in the best interests of those who lived at the home. Therefore, this was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 17 March 2015 we found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective. Therefore, this area was in need of improvement. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 30 June 2015.

At this inspection we found significant improvements had been made in this area. The systems which had been implemented for assessing and monitoring the quality of service provided were robust. Therefore,

whilst the previous breach of the Health and Social Care Act regulations had been met, we have still made a recommendation around this area.

At this inspection we looked at the personnel records of two staff members recruited. We found that on this occasion staff had been appropriately appointed and therefore people who lived at The Barn were protected by the recruitment practices adopted by the home.

Regular supervision sessions for staff were being conducted. Annual appraisals were in the process of being introduced. We found that a varied training programme had been provided for the staff team, which helped them to keep abreast of current practices and any changes in legislation. However there were some gaps found in the knowledge and skills of staff in managing people's nutritional and hydration needs. We have made a recommendation that the provider ensures that all staff have had the appropriate training to ensure they have the skills and knowledge to adequately meet people's nutritional and hydration needs.

At this inspection we found the environment to be warm and comfortable. We observed staff members interacting well with those who lived at The Barn. People looked happy and comfortable in the presence of staff and were enjoying their company.

Fire procedures were easily available, so that people were aware of action they needed to take in the event of a fire and records we saw good information provided about how people needed to be assisted from the building, should the need arise. Records showed that equipment and systems within the home had been serviced in accordance with the manufacturer's recommendations. This helped to protect people from harm.

The service had reported safeguarding concerns to the relevant authorities and suitable arrangements were in place to ensure that staff were deployed, who had the necessary skills and knowledge to meet people's needs safely. A range of health and safety training was provided for the staff team.

People we spoke with were aware of how to raise concerns, should they need to do so. A complaints procedure was in place at the home and a system had been implemented for the recording of complaints received. People's privacy and dignity was consistently respected.

The service worked well with a range of community professionals. This helped to ensure that people's health care needs were being appropriately met. People told us they enjoyed the meals provided. People we spoke with were complementary about the staff team. They felt that they were treated in a kind, caring and respectful manner. People expressed their satisfaction about the home and the services provided.

Regular meetings were held for the staff team. This enabled those who worked at the home to discuss topics of interest in an open forum. Staff we spoke with told us they were happy with the current staffing levels. However, we noted that care staff were responsible for all the ancillary duties, as well as the provision of care and support. We have made a recommendation about the provider reviewing the possibility of appointing ancillary staff to enable care staff to focus on their caring roles.

'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?

This service was not always safe.

Recruitment practices adopted by the home helped to ensure that only suitable staff were appointed to work with the vulnerable client group.

The home was, in general clean. However, infection control was not always being promoted.

Risks assessments were in place and medicines were mostly being well-managed.

Safeguarding referrals had been made to the relevant authorities and emergency plans had been generated, so that people were kept safe.

Staff members were aware of the procedures to follow should they have concerns about the welfare of those who lived at the home.

Requires Improvement ●

Is the service effective?

This service was not always effective.

Records showed that staff received a good induction programme when they started to work at the home. This was followed by a range of training programmes and regular supervision. Annual appraisals were in the process of being developed.

Mental capacity assessments had not always been conducted, in accordance with the Mental Capacity Act and consent had not always been sought in an appropriate way.

Areas of the premises were in need of modernising and upgrading. Meal times were being well managed.

Requires Improvement ●

Is the service caring?

This service was caring.

Staff were seen to be kind, caring and respectful of people's

Good ●

needs.

Those who lived at The Barn were supported to access advocacy services, should they require this service.

Records were retained in a confidential manner and people's privacy and dignity was consistently respected.

Those who lived at the home were supported to maintain their independence, as far as possible and staff members communicated well with those in their care.

Is the service responsive?

Good ●

This service was responsive.

The plans of care were based on assessments of people's needs and they were person centred and well written documents.

People were supported to maintain their leisure interests, whilst living at the home. Some people gave us examples of community based activities, in which they were involved, as well as in-house activities.

Complaints were being well managed.

Is the service well-led?

Requires Improvement ●

This service was not consistently well-led.

The views of people who had an interest in the home were sought annually. People we spoke with were happy living at the home.

The home had introduced good systems for assessing and monitoring the quality of service provided and a wide range of policies and procedures were in place at The Barn. However, some areas in need of improvement, as identified by the inspection team had not been picked up by the managers of the home.

Regular meetings for those who lived at the home were arranged and staff meetings were held frequently. This allowed important information to be disseminated and enabled people to discuss any relevant topics in an open forum.

The Barn

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 had addressed the breaches identified at the previous inspection, if they were 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 new rating for the service under the Care Act 2014.

This inspection was unannounced and was conducted by two Adult Social Care inspectors from the Care Quality Commission (CQC). At the time of our inspection there were nine people who lived at The Barn. We were able to speak with three of them. We received positive comments from those we spoke with. No relatives visited the home during our inspection.

We also spoke with three members of staff and the registered manager of the home. We toured the premises, viewing a selection of private accommodation and all communal areas. We observed the day-to-day activity within the home and we also looked at a wide range of records, including the care files of three people who used the service. We pathway tracked the care of three people who lived at The Barn. Pathway tracking is a system we use to ensure people are receiving the care and support they need. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

We also looked at the personnel records of two staff members, which helped us to establish the robustness of the recruitment practices and the level of training provided for the staff team. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

The provider completed and submitted a Provider Information Return (PIR) within the time frames requested. A PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents, deaths and

safeguarding incidents. We also looked at the information we had received from other sources, such as the local authority and community professionals involved in the care and support of those who lived at the home.

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at The Barn and that they were very happy being at the home.

During the course of this inspection we found that infection control protocols were not being well managed. We established that one person, who was receiving treatment for scabies was entering the laundry, kitchen and other people's bedrooms and lying on their beds without being redirected or assisted to other parts of the home. This was discussed with the area manager at the time of our visit, who assured us that infection control protocols would be implemented without delay, in order to reduce the possibility of cross infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members we spoke with told us they were happy with the current staffing levels. We were told that additional staff were allocated when needed, in order to facilitate outings and appointments. However, we established that care staff completed all the ancillary duties, as well as their caring roles, because the home did not employ domestic staff, laundry assistants, catering staff or activity coordinators. This could have potentially had an impact on the provision of care and support. Some people who lived at the home required a high level of care intervention and observation. We recommend that the provider reviews the possible appointment of ancillary staff, in order to enable the care staff to focus on their caring role.

The care records for one person showed that detailed health and social care risk assessments had been undertaken and recently reviewed for areas such as aggression, with robust action plans being developed. This helped to reduce the potential element of risk. This information was also linked to the plan of care, which gave a good picture of the individual's needs. There was evidence available to demonstrate that some staff members had signed to indicate they had read and understood this individual's care plan and risk assessment. Other risk assessments, which had been conducted, were in relation to moving and handling, nutrition and skin integrity.

We saw that a range of environmental assessments had been conducted, within a risk management framework, in order to keep people safe. These included security, open windows, moving and handling equipment, domestic products, fire safety, spillage of bodily fluid and laundry and kitchen equipment. Staff members had signed each risk assessment, indicating they had read and understood the contents. This helped to ensure that staff were aware of the risks and action they needed to take in order to keep people safe.

A fire risk assessment had been developed and Personal Emergency Evacuation Plans [PEEPS] had been implemented, which were retained in a separate, easily accessible file. This helped to ensure that the emergency services could assist people to vacate the premises in a safe manner, should evacuation be necessary in the event of emergency situations, such as fire or flood.

A monthly health and safety audit was conducted, which covered areas, such as furniture and fittings, the

décor of the premises, floor coverings, curtains and blinds, window and door closures, electrical equipment and switches and lights. We noted that the Environmental Health Officer's most recent inspection in relation to food safety had resulted in an award of level 5, which is the highest level achievable.

We found that there had been some improvements in the standard of cleanliness of the environment since our last inspection. However, due to the age of the internal fixtures and fittings the premises were difficult to clean thoroughly. We looked at infection control practices adopted by the home. There were cleaning schedules in place, which covered all areas of the home, an infection control policy had been implemented and specific audits were conducted each month. We found that personal protective clothing [PPE] was stored appropriately and good practice was maintained around the disposal of clinical waste.

During our inspection we assessed the management of medicines. Each person had a locked cupboard in their rooms, for the storage of medicines. Their medication administration records (MAR) were also retained in people's rooms. This promoted person centred care. The staff member who was responsible for the administration of medicines on the day of our inspection had received medication training as part of their induction and this had been followed by a series of competency based observations.

We observed a medication round and found that this was conducted in a dignified and professional manner. Infection control protocols were followed. For example, the administering senior care worker wore gloves at all times during the process.

We looked at the MAR charts of five people who lived at The Barn. The receipt of medicines was appropriately recorded and any bottles of eye preparations or cartons of creams were dated on opening. All medicine stocks were in date. Records showed how staff should approach one person whose behaviour challenged the service, in relation to the taking of their medicines. However, hand written entries on the MAR charts had not always been signed, witnessed and countersigned in order to reduce the possibility of transcription errors. We recommend that all hand written entries are signed by two members of staff to ensure accuracy.

There were no 'as and when required' medications available for one person, as they did not take these, so it may be appropriate to discontinue the prescription. We noted the care records of one person showed that they were supported to apply their own topical creams and a good record was maintained about how they liked to take their medications.

The Medication Administration Records [MARs] included any known allergies, which helped to reduce the potential of specific medications or foods being given, in order to prevent allergic reactions from occurring. We found the medication plans of care to be person centred, which included how and when people liked to take their medications. Potential risks had been identified and reviewed with appropriate plans in place to meet people's needs.

Medicines were stored in a secure room and maintained at safe storage temperatures. All the medication records we viewed, except for one contained a photograph of the relevant person to help reduce the risk of identification errors. Important information, such as any known allergies had also been included. We looked at how the service managed controlled drugs. We found that these were stored safely and the recording of administration was accurate.

A business continuity plan had been developed, which outlined what action staff needed to take in the event of an emergency situation arising, such as gas leak, power failure, flood, fire or adverse weather conditions. This helped to ensure that people were protected from harm.

Records showed that systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to make sure they were fit for use and therefore promoted people's safety. Any accidents were recorded in line with data protection guidelines. This helped to protect people's identity and to ensure records were maintained in a confidential and secure manner. We saw that incidents were recorded and investigations were conducted by the local authority or the home, if deemed appropriate. This helped to ensure that all incidents were responded to in a timely manner.

There was only one incident recorded in the incident file for 2016. However, there was evidence available to show that three medication errors had occurred in 2016. We looked at these records and found that none were signed by the person compiling the report or by their line manager. They had not been reviewed by a more senior manager. However, all three showed that appropriate action had been taken by the home. For example, medical advice had been sought, action plans had been implemented and safeguarding referrals had been made. We recommend that all incident forms are appropriately signed, dated and reviewed.

The service had reported safeguarding concerns to the relevant authorities and suitable arrangements were in place to ensure that staff were deployed, who had the necessary skills and knowledge to meet people's needs safely. Lessons learnt were discussed at subsequent staff meetings. A range of health and safety training for staff was provided.

Records showed that some internal checks were completed regularly in order to protect people from harm and it was evident that where shortfalls were noted, then these were followed up and action taken to rectify the problem. For example, a few days prior to our inspection the monthly hot water temperature recordings were shown as being below the recommended levels, so this was being investigated, in order to address the issue. Records showed that little used water outlets were flushed each week and shower heads were cleaned and disinfected periodically. The fire alarm system and escape routes were checked each week, to ensure they were in good working order. Information was readily available for staff in relation to fire safety and records showed that a simulated fire evacuation practice was instigated from time to time. This helped to ensure that the staff team was competent to follow the fire procedures of the home.

During the course of our inspection we looked at the personnel files of two staff members. We found that robust recruitment practices had been adopted by the home. Application forms and health questionnaires had been completed and a record of interviews had been retained. References had been obtained and Disclosure and Barring Services [DBS] checks had been conducted before people started to work at The Barn. DBS checks allow managers to establish if any prospective employees have a criminal record or if they have received any cautions, to enable employers to make a decision about appointing them.

Is the service effective?

Our findings

People we spoke with told us that they enjoyed the food served and that they were happy with the staff who looked after them.

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 care records of one person showed that they were not under continuous supervision and control and that they were free to leave the home if they wished to do so. However, a mental capacity assessment had not been conducted to establish if this person had an impairment of the mind that might affect their capacity to make decisions in relation to leaving the building. We discussed this with the registered manager of the home, who told us this person was vulnerable, but confirmed that they would be free to go out alone if they wished, although they chose not to do so. However, this information was not reflected in their plan of care and a risk assessment in relation to them going out alone had not been completed.

We found that Mental Capacity Assessments had not always been conducted, in order to determine capacity levels, prior to important specific decisions being made and Deprivation of Liberty Safeguard applications being submitted. Also evidence was not always available to demonstrate that decisions had been made in the best interests of those who lived at the home. Therefore, this was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A policy was in place at the home in relation to the MCA and Deprivation of Liberty Safeguards (DoLS). The records of one person showed that a standard DoLS application had been refused in 2014, as the person did not meet all the criteria needed and therefore it was deemed that their liberty was not being deprived. A new application had recently been submitted for this person to the local authority, as the mental capacity assessment showed that the individual lacked the capacity to make some decisions about their care and welfare.

Consent forms covered a range of areas, such as advance decisions, sharing of information with relevant professionals, staff entering bedrooms, being accompanied to medical appointments, emergency first aid and medical treatment. The consent forms showed that people had the right to withdraw consent, if they so

wished and some of these were in easy read formats, which allowed people easy access to the information.

We found the assessment for the self-administration of medicines that had been completed in 2014 and had only been signed by the manager at that time. We looked at another person's care file. This also contained a self-administration of medication record showing that they would need support with the administration of their medicines. However, this was only signed by a staff member on their behalf. We also found the care records for one person showed that their consent forms had been signed by the individual to whom they related. Another person had also signed their own consent forms. However, this individual's DoLS application stated that they could not give consent to their care and accommodation. A support worker had signed the consent forms on behalf of another person, who lived at the home.

One of the consent forms we looked at stated that the person's money and cash card would be held in the safe at the home and staff would support the individual with their finances. However, this person's care records stated that a family member was their appointee for finances, although no legal documentation was retained within the care records. People are not able to give consent on behalf of someone, unless they have the legal authority to do so. There was no evidence available to demonstrate that meetings had been held to ensure decisions had been made in the best interests of the individuals, whose consent forms had been signed by a support worker. These failures to obtain valid consent and follow the principles of the MCA amounted to a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we toured the premises and found that although the management of the home had made some improvements to the environment, the premises were in need of upgrading and modernising. Paintwork was scratched in many places and a shower chair was rusty and in need of replacing. However, we were told that where decoration had been completed that those who lived at the home had participated in the choice of colours and design. Specialised equipment was provided, as was needed, such as ceiling tracking hoists and specialised chairs and beds. Mobile door bells had been provided for those who found it difficult to mobilise, so that they could summon staff assistance from anywhere in the home. This helped to promote safety and comfort for those who lived at The Barn.

New employees were issued with a good amount of information, which helped them to understand what was expected during their employment at The Barn. An employee handbook, job descriptions relevant to specific roles and terms and conditions of employment were given to all new staff. Together these contained relevant information about important policies, such as disciplinary and grievance procedures, equal opportunities and effective communication. This helped to ensure that new staff were supported to do the job for which they were employed.

Induction programmes for new staff were extremely detailed and covered a wide range of learning modules, such as confidentiality, fire safety, health and safety, roles and responsibilities, discipline and grievance, code of conduct, whistle-blowing and safeguarding.

A schedule of supervision sessions for staff was available, which showed that most staff had received structured supervision in January 2017 and that these were conducted every six weeks. Supervision records were well structured and it was clear that these were based on individual strengths. Senior staff had received supervision training, which helped them to manage supervision sessions for their staff members and to support them in the most effective way. The registered manager told us that there were plans in place to introduce annual appraisals for all staff.

Certificates of training were retained on staff personnel records. These were several years old in most cases. However, training records showed that each staff member was provided with a wide range of training

modules, including behavioural support training, which helped to ensure that the staff team were able to support those whose behaviour challenged the service. Other learning sessions included, safeguarding, medicine management, fire safety, infection control, food safety, moving and handling, health and safety, MCA and DoLS and first aid. Additional training courses had been provided also, such as epilepsy, dementia awareness, autism and person centred approaches. However, one member of staff told us that they had not had any training in relation to the specific needs of one person who lived at the home. One staff member told us that most of the training was e-learning on the computer, but that face to face training was also provided, for sessions, such as moving and handling, which was more practical based.

We noted that one person was not served puddings, because they were diabetic and the staff had not received appropriate training for the provision of a diabetic diet. We also noted that everyone who lived at the home had a food and fluid intake chart. These charts were not being completed well in relation to the amounts of diet and fluids taken. Therefore, where monitoring was needed the charts were ineffective. We recommend that the provider ensures that all staff have had the appropriate training to ensure they have the skills and knowledge to adequately meet people's nutritional and hydration needs.

We observed people being offered a variety of choices throughout the day and people told us that they enjoyed the food served. Snacks and drinks were available between set meal times.

Records showed that hospital passports and health action plans were in place. These contained important details about the health and social care needs of people. This would assist hospital staff to provide effective care and support, should a hospital transfer be necessary.

The plans of care we saw showed that consideration had been given to 'living well', which focussed on healthy lifestyles and educating people about staying healthy. We found that partnership working was evident and that people were referred to a wide range of community health care professionals in a timely manner, including mental health teams, nutritionists, dieticians, GPs, chiropody and optical services. One person attended a hospital appointment on the day of our inspection. This helped to ensure that people's health care needs were being appropriately met.

Is the service caring?

Our findings

There were nine people who lived at The Barn at the time of our inspection. We spoke with three of them, who provided us with positive feedback about the level of service they received and the caring attitude of the staff team.

We observed people receiving good support throughout the day, with their independence being promoted. We saw staff interacted well with people in a pleasant and kind manner and approached them with respect. Staff members were seen to speak with people at a pace comfortable to the individual. They allowed time for information to be processed and a response to be provided in the person's own time, before proceeding with the next speech or action. This promoted a person centred approach and demonstrated a caring and unrushed attitude.

Everyone looked well-presented and it was evident that people were treated equally. We overheard staff members speaking with people in a respectful manner and staff were seen to approach people in a kind way. They also helped people to remain as independent as possible. It was evident from our observations that staff knew those who lived at the home well.

Personal records were retained in a confidential manner and staff promoted people's privacy and dignity by knocking on bedroom doors before they entered. We saw staff members providing explanations and involving people in decisions about their care before this was delivered.

The home had held 'Dignity days', in order to promote dignity and respect, with dignity leaflets in easy read formats, allowing equal opportunities for everyone to access the same information. The care records we saw outlined the importance of promoting people's privacy, dignity and independence.

We saw that people appeared relaxed in their surroundings and comfortable in the presence of staff members. The care plans we saw showed that people had made some decisions about end of life care. This helped to ensure that their wishes would be followed in the last months or days of their life.

There was evidence available to show that some people were supported to maintain contact with their family and friends and one person had been supported by an advocate to assist them in decision making. An advocate is an independent person, who will support people to make specific decisions, which will be in their best interests. This demonstrated this individual's best interests were considered and that they were supported to access services relevant to their needs.

Is the service responsive?

Our findings

We found that the care planning system had significantly improved since the last inspection. Care plans we saw had been reviewed regularly and any changes in need had been reflected well. The plans of care were detailed and well written documents, providing staff with good person centred information about those in their care. Personal history and life story information throughout people's care records were completed to a good standard. We saw one page profiles, which included sections, such as 'what makes me upset', 'what makes me happy', 'what I enjoy' and 'how to support me'. The plans of care and risk assessments could have been linked together more, but this was discussed with the registered manager, who we were confident would look at doing this.

We found each care record contained a comprehensive and person centred pre-admission assessment, which had been undertaken, prior to people being offered a place at The Barn. This helped the staff team to ensure that they were able to deliver the care and support required. People's assessed needs were incorporated well into the plans of care and clear guidance was available to show how these needs were to be best met. For example, the plan of care headed, 'Health and well-being' for one person described how topical applications and specialised stockings should be applied, in order to be most effective. Evidence was available to show that some people had been involved in developing their plans of care. Observations of care interactions throughout the inspection were positive. Evidence was available to show that the service worked effectively with external professionals, such as community health care workers and social workers. This helped to ensure that the health and social care needs of people were being appropriately met.

The care records we saw showed that people were supported to maintain their leisure interests, whilst living at The Barn. For example, it was evident that one person attended a discotheque twice a week, a church group each week and continued to enjoy regular dance classes. People's likes and dislikes were also taken into consideration when planning their individual activity programmes. One person enjoyed doing household tasks, such as washing and drying the pots, hoovering, assisting with meal preparation and polishing and they were supported to participate in these activities. Another person gave us some examples of activities they enjoyed doing. These were, music sessions and discos and attending football matches and the local football club. Some people enjoyed a market trip or a fitness group, whilst others liked to go shopping or for a meal out.

People's bedrooms were personalised and matched their specific interests and life styles. For example, one person who had sensory disabilities and preferred their own company chose to remain in their bedroom most of the time had an abundance of sensory fibrotic lights in their room, such as illuminated ropes and spectacular light displays. Another person, who was a Blackburn Rovers fan and an avid train spotter, had memorabilia, photographs and models adorning their bedroom. This promoted individuality and person centred care.

We were told that each Sunday a meeting is held between the service users and staff to plan the menu for the following week, so that a shopping list could be compiled in preparation. It was evident that people were

able to choose what they wanted to eat.

People we spoke with were confident in making a complaint, if they needed to do so. A complaints policy was in place at the home, which outlined specific timescales for responses to be provided and a system was in place for recording any complaints received. However, none had been recorded within the last twelve months. Evidence was available of the managers meeting with individual families to discuss any concerns in an open and transparent manner.

Is the service well-led?

Our findings

The registered manager was on duty at the time of our inspection. She had managed the day to day operation of the home for one year. The area manager attended the home during our inspection, who had been in post for a very short period of time and who acknowledged that some improvements were needed. The area manager told us of plans to redevelop the existing space to provide an environment which was more suitable for the needs of those who lived at the home.

A Statement of Purpose was in place, which provided any interested parties with information about the services and facilities available at the home. Good systems had been established to effectively assess and monitor the quality of service provided. These included a range of monthly audits in relation to quality monitoring, which covered areas such as performance related issues, recruitment, training for staff, supervision and personal development, medications, infection control, DoLS, accidents and incidents, activities, the environment, health, safety and security, experiences of service users and experiences of staff, staffing, care planning and staff personnel records. These processes helped to measure the quality of service provided so that any areas in need of improvement could be identified and addressed in a timely manner. Action plans had been generated following some audits and this was under further development. However they had not picked up on some of the failings found during this inspection. We would therefore recommend that the provider ensures some of these processes are made more robust.

The registered manager told us that she was involved in the autistic framework. This had been developed by the organisation and there was a positive behavioural facilitator appointed within the company. This facilitator was involved in care plan reviews and helping staff members to adopt more proactive approaches to people's needs. We observed that staff were competent in recognising people's needs from their ways of communication.

A business plan was in place and a wide range of policies and procedures were available at the home. These included areas, such as missing persons, infection control, fire safety, confidentiality, complaints, safeguarding vulnerable adults, health and safety and the Mental Capacity Act and Deprivation of Liberty Safeguards.

A system was in place for obtaining annual feedback from residents, relatives, staff and stakeholders within the community about the quality of service provided. An action plan had been developed from the responses received, so that any issues raised could be addressed without delay. The surveys for those who lived at the home covered areas, such as the service, visitors, activities, staff, safety and security and accommodation. Structured empowerment meetings were also held, which enabled those who lived at the home to manage the meetings themselves, with support, if needed.

Records showed that meetings were held very regularly for those who lived at The Barn. These meetings covered areas, such as house maintenance, complaints and compliments, competitions, infection control, trips out, activities, safety, dignity and house updates. This was followed by an open question and answer session, which enabled people to ask questions about something that may have concerned them or be of

particular interest. The minutes of the last meeting in February 2017 showed that the topic of dignity was discussed, which included respect, maintaining confidence, self-esteem and loneliness. Someone had asked what abuse was. Good explanations were given, supported by pictorial descriptions, for easy reference.

The registered manager told us that processes were being implemented, so that the skills of those who lived at the home were taken into consideration more. These could then be used in a more positive way, to help them progress with life skills and to encourage them to become more involved in the day to day operation of the home. A peer support system was also being established, which would help those who lived at the home to receive the support they needed.

Records showed that regular meetings were held for the staff team during which, lessons learnt from any incidents were identified and discussed. This enabled the workforce to discuss topics of interest in an open forum and to raise any issues or areas of good practice with colleagues and managers.

The registered manager of the home was aware of the need to notify the Care Quality Commission of certain events, such as allegations of abuse, unexpected deaths and incidents resulting in serious injury.

The company had been accredited with an external quality award, which involved an independent professional organisation periodically auditing the business, to check if acceptable standards were being maintained.

Although there were a lot of positive aspects of the service being well-led, there were areas picked up by the inspection team, which should have been identified by the managers of the home. For example, Mental Capacity Assessments not being conducted prior to DoLS applications being made, consent not being obtained appropriately, infection control practices not being promoted and nutritional and hydration needs not always being met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>We found that consent had not always been sought in an appropriate way. We also found that Mental Capacity Assessments had not always been conducted, in order to determine capacity levels, prior to important specific decisions being made and Deprivation of Liberty Safeguard applications being submitted. Also evidence was not always available to demonstrate that decisions had been made in the best interests of those who lived at the home</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>We found that the registered person was not promoting good infection control practices within the home.</p>