

Aitch Care Homes (London) Limited

# Coneyhurst Lodge

## Inspection report

68 St Lawrence Avenue  
Worthing  
West Sussex  
BN14 7JJ

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13 April 2016

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Good 

# Summary of findings

## Overall summary

Coneyhurst Lodge provides accommodation and personal care for up to ten people with a learning disability and complex needs under the age of 65 years. At the time of our visit ten people were living at the service. It is situated in a residential area of Worthing, West Sussex. People had their own room and there was a dining and lounge area. In addition, there is a quiet lounge and a garden sensory room for people to use.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive the care or support they required. During our inspection we saw one person who appeared to be agitated and staff did not take action to engage with them to ensure their needs had been met.

People's support plans were not always reviewed and updated as needed and information available to staff did not always reflect their current needs. We saw that people's positive behaviour support plans had not been reviewed for a considerable period of time. A communication aid, identified in one person's care plan, was not being used by staff to support them. However their care plan had not been updated to reflect the support the person currently received to meet this need. There were not enough meaningful activities for people to take part in and activity records showed that people were not taking part in activities as planned.

People were protected by staff who knew how to recognise and report the signs of abuse. Staff had received regular safeguarding training.

Safe recruitment practices were followed. Disclosure and Barring Service checks (DBS) had been requested and were present in all checked records. There were sufficient numbers of staff on duty to keep people safe and meet their needs.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

Staff received all essential training had monthly supervision meetings and annual appraisals. People had access to healthcare professionals and all their appointments were recorded in a diary.

People's rights were upheld as the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards had been adhered to. The registered manager had made applications for all the people living at the home. We were told that these had been carried out with support from the community psychiatric nurse to ensure they accurately reflected people's current level of need.

Staff encouraged people to remain as independent as possible. We saw that the guidance in people's care plans reminded staff to encourage people to be as independent as possible.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Staff had received safeguarding training and knew how to recognise and report abuse

There were sufficient numbers of staff to make sure that people were safe and their needs were met

Risk assessments were in place and were regularly reviewed to ensure that they reflected people's current level of risk

Medicines were managed safely.

### Is the service effective?

Good ●

The service was effective.

Staff had received training as required to ensure that they were able to meet people's needs effectively

People were supported to maintain good health and had regular contact with health care professionals

People's rights were protected as the principles of the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards (DoLS) were followed.

People had enough to eat and drink and people were encouraged to be involved in meal preparation where possible.

### Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Concern was not always shown for people's wellbeing and action taken to relieve distress.

People were involved in making decisions and planning their care.

### Is the service responsive?

The service was not consistently responsive.

There were not enough structured and meaningful activities for people to take part in.

Communication aids were not consistently used within the service. This impacted upon people's ability to communicate effectively.

Care plans were not up to date for all people and may have led to people receiving inconsistent care.

Complaints were dealt with promptly and in an informal way.

**Requires Improvement**



### Is the service well-led?

The service was well led.

Staff felt able to discuss any concerns with the registered manager.

Quality assurance systems were in place and were used to improve the service.

The registered manager was aware of concerns regarding the service provided and was taking action to address these.

**Good**



# Coneyhurst Lodge

## **Detailed findings**

### Background to this inspection

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

The inspection took place on 12 and 13 April 2016 and was unannounced. One inspector and a specialist advisor undertook the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the home and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed feedback from health and social care professionals. We used all this information to decide which areas to focus on during inspection.

Some people living at the service were unable to tell us about their experiences; therefore we observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the two people, three relatives, the registered manager, the deputy manager, the locality manager and four members of staff. We looked at five care records, three staff records, medication administration record (MAR) sheets, staff rotas, the staff training plan, logs of complaints, quality assurance audits and other records relating to the management of the service.

This was the first inspection since the service was registered on 7 January 2014.

# Is the service safe?

## Our findings

Relatives felt that their family members were safe and one family member told us they had, "No concerns about (named persons) safety". People were kept safe by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, emotional and neglect and knew how to respond to safeguarding concerns. A member of staff explained that they would discuss any concerns with the registered manager and were confident they would take these seriously and respond appropriately. The staff member told us, "Everyone is clear on their responsibilities and the whistle blowing procedure". If they did not feel the response was appropriate they knew which outside agencies to contact for advice and guidance. The registered manager was clear on their responsibilities and what agencies should be contacted.

Systems were in place to identify risks and protect people from harm. Risk assessments were in place to identify individual risks and these were reviewed monthly or sooner if needed. Where someone was identified as being at risk actions were identified on how to reduce the risk and referrals were made to health professionals as required. Staff were aware of how to manage the risk associated with people's care needs and how to support them safely. Risk assessments were in place for issues such as behaviour which may challenge and also for activities outside of the service. We saw that there were various risk assessments in place for activities such as swimming and trampolining. One person had a risk assessment in place which provided guidance for staff on how to ensure they travelled safely by taxi.

There were sufficient numbers of staff on duty to keep people safe and meet their needs. We reviewed the rota and the numbers of staff on duty matched the numbers recorded on the rota. Staff told us they felt there were enough staff on duty. We saw that there were two members of waking night staff on duty. We observed that people were not left waiting for assistance and people were responded to in a timely way. We looked at the staff rota for the past four weeks. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered. Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all checked records. Staff files also contained two positive references and documents relating to previous training completed. People told us they felt there was enough staff and that they were responded to in a timely way.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored and given to people as prescribed and disposed of safely. We observed medicines being administered and saw that the staff who administered medicines did this safely. Staff confirmed they were confident and understood the importance of this role. Medication Administration Records (MAR) were in place and had been correctly completed to confirm medicines had been given as prescribed. Each person had an individual record of how they liked to take their medicines. Medicines were locked away as appropriate and where they were required to be refrigerated, temperatures had been logged and fell within guidelines that ensured effectiveness of the medicines. Medicine which was no longer needed was stored safely ready for collection by the pharmacy. We completed a random spot check of two people's medicines and they matched the records kept. Only

trained staff administered medicines. Medicines were given by the senior member of staff on duty and were checked by another member of staff on duty to ensure medicine records were completed correctly.



# Is the service effective?

## Our findings

The service made sure that the needs of people were met consistently by staff who had the right knowledge, qualifications and skills. Staff spoke with us about the range of training they received which included safeguarding, food hygiene and moving and handling. Staff records reviewed confirmed that all staff training was up to date. Staff had also undertaken training specific to meet the needs of people living at the service including autism and epilepsy training. New staff undertook a comprehensive induction programme which included essential training and shadowing of experienced care staff. Staff had completed the provider's induction checklist which involved staff familiarising themselves with the layout of the building, fire safety procedures, policies and procedures and reading through care plans. New staff also received a six month probation review which focussed on their development and any additional training which was needed.

Supervision was used to develop and motivate staff and gave staff the opportunity to review their practice. There was a formal supervision and appraisal process in place for staff and action which had been agreed was recorded and discussed at each supervision meeting. Staff received supervision every month and also had an annual appraisal. They received supervisions and appraisal minutes which detailed what had been discussed. Staff confirmed they had regular supervisions and told us they found these helpful. They discussed the people they supported and any areas of personal development to ensure staff skills and knowledge in caring for people.

Consent to care and treatment was sought in line with legislation and guidance. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that applications had been made to deprive nine people living at the service of their liberty under a DoLS and two applications had been authorised. However we also saw that one person's authorisation had expired in June 2015 and a further application had not been made. We spoke with the registered manager and they told us that this was an oversight and they would submit an application for further authorisation. Applications had been submitted for the seven other people and were awaiting authorisation by the local authority. We saw that people had capacity assessments within their care records which had been completed appropriately for people. Where decisions needed to be taken relating to finance or health, for example, then a best interest decision would be made, involving care professionals and relatives to make a decision on the person's behalf in their best interest. Where possible, the person would also be included in this decision-making.

People were able to make day to day choices and decisions. We saw that people were asked if they would like support during their daily routines and lunchtime meal and staff understood the importance of ensuring consent before providing support. Staff understood the requirements of the Mental Capacity Act 2005 and spoke with us about the MCA and DoL's training they received. We saw staff followed the principle of presuming that people had capacity to consent by asking if they wanted assistance and waited for a response before offering support. If staff were unsure if the person wanted support they would wait and speak with the person a few minutes later to attempt to gain consent.

Health professionals spoke positively of staff responses to people's health needs and said, "Staff really do cope well". People experienced positive outcomes regarding their health as they were supported to maintain good health and have access to health professionals. Staff worked in collaboration with professionals such as doctors, psychologist and the chiropodist to ensure advice was taken when needed and people's needs were met. People's care records contained a section which detailed the contact which had been made with the health care professionals such as the GP and noted advice and guidance which had been received. For example, we saw there was ongoing contact with health professionals about changes to one person's mood and behaviour. Changes to medicines were recorded within their care records. Hospital passports had been completed for people. These provided details for hospital staff about people's medical history and health conditions if they needed to be admitted to hospital. People's healthcare appointments were recorded in an appointment diary which reminded staff when appointments were due.

Staff handover meetings took place between shifts to ensure that staff could pass on information to staff on the following shift. We observed a staff handover and saw that each person was discussed including the activities they had planned to take part in and any changes to people's moods. There was also a daily shift planner which was completed by the senior member of staff. Staff meetings took place regularly and the manager told us they tried to have one every month.

Relatives felt that people had enough to eat and drink and their personal preferences were taken into consideration. We observed a lunchtime experience and saw that people were supported to have enough to eat, drink and maintain a balanced diet. People were involved in the preparation of food where possible. On the day of our inspection we saw one person helping to prepare lunch in the kitchen with staff. Pictures of food were used to display the lunch menu choices for the day to support people who were unable to read words. Staff encouraged people to eat and offered to refill drinks. Staff were seen cutting people's food into smaller pieces when needed. People were also provided with plate guards to allow them to remain independent with eating. People's hydration needs were met and we saw people were offered regular hot and cold drinks throughout both days of our inspection. With their permission people who were at risk were weighed on a monthly basis and referrals or advice was sought where people were identified as being at risk. There were weekly meetings for people living at the service which they spoke about the menu choices and which meals they would prefer that week. People also accompanied staff to the local shops and green grocers to choose fresh food for meals.

## Is the service caring?

### Our findings

Relatives had a mixed response when we spoke with them about the caring nature of staff and described staff as, "Kind and caring" and told us they, "Really tried". Another relative told us they felt that members of staff, "Didn't seem to bother" and also said staff "Didn't take care of [named person's] possessions".

Health care professionals spoke positively of the atmosphere in the service and one professional told us that staff were, "Always attentive to the needs of residents". They also told us they would be, "Quite happy to place a member of my family". We observed during both days of our inspection staff were mainly gentle and friendly when they spoke with people and were quick to respond to requests in a kind and pleasant manner. Staff took time to speak to people and offered explanations.

However, we also observed that action was not always taken by staff to respond to people's needs. We saw one person who spent time in the lounge area and walked around the hallway. This person seemed to become agitated. They moved from chair to chair and waved their arms. There were three members of staff in the lounge area talking with one other person and this behaviour was not acknowledged by the staff members. Staff made limited eye contact with this person and did not attempt to engage with them. We spoke with the registered manager and they told us, "(named person) at times is supervised rather than supported". The registered manager also told us they had requested intensive interaction training to improve the staff's understanding of engaging with people, however there was no planned date of this training.

We recommend that the provider give further consideration to ensuring that people are consistently treated in a caring and compassionate way.

We also observed positive interactions between staff and people which showed dignity and respect. We spent time observing the care practices in the communal areas and saw that people's privacy and dignity were maintained. We saw a member of staff sensitively remind one person to fix their clothing to ensure their dignity was respected. Staff knocked on people's doors before entering and made sure they were happy for them to enter the room. We spoke with staff about how they ensured people received care in a way that promoted their dignity. Staff told us they ensured that door and curtains were closed before they offered support with personal care. Staff also told us they focused on involving people in personal care tasks where possible. They spoke with us about the, "Hand on hand approach" that when possible they used with people during personal care tasks, and described how they ensured that people were involved in carrying out their own personal care tasks while receiving support. They told us this promoted people's dignity while ensuring they felt in control during personal care tasks.

People were encouraged to be as independent as possible. People's care plans detailed tasks they were able to carry out for themselves and what tasks they needed support with. Guidance was available for staff on the support people needed with personal care such as, 'Check temperature of bath' and, 'Verbal prompts to ensure good hygiene'. A member of staff spoke with us about the support they offered with teeth brushing. They encouraged the person to brush their teeth themselves and would offer assistance when

needed. Staff offered support with housework tasks and encouraged people to be as involved as possible. Within people's care plans there was a section, "'What I am Good at'". This focused on people's strengths and abilities such as, 'Using my tablet independently' and, 'I am good at loading the washing machine'. Staff also supported people in the community and when visiting the local shops. One person enjoyed walking to the local shops and chose drinks and snacks which they enjoyed. A member of staff told us, "We take (named person) to the shops and he chooses his own drinks". The registered manager told us they were focusing on, "Finding ways to gather information on what works and find ways to give people as much choice and control as possible".

People were involved in the decisions about what care they received and in their decisions about daily routines. Staff spoke with people and gained their consent before providing support or assistance. A member of staff spoke with us about the choices they offered people including in selecting their clothes. They would get a selection of clothes from the wardrobe and ask people to choose which they would prefer to wear. People chose where they ate their meals; some people preferred the dining room while others preferred the lounge area. We saw that these preferences were recorded in people's care records. People's care plans also recorded preferences on food including how they liked their breakfast. One person's care plan recorded "I like to be offered a choice of cereal and I always have two slices of toast with peanut butter". We spoke with staff about how they communicated with people who were unable to communicate their wishes verbally. They told us they watched their facial expression and gestures to understand their views. If someone refused their assistance they would respect their decision but would return later and offer support again. People's rooms were personalised with items such as ornaments and family photographs. Weekly activity and menu choice meetings took place between staff and people. Discussions were held on what activities people would like to take part in and what their preferences were for meals that week.

Family and friends were able to visit without restriction. Relatives were made to feel welcome and felt comfortable discussing any changes or updates to the care their relative received. People were encouraged to stay in contact with people who mattered to them and family members had arranged times for people to call them. We saw that people's care plans recorded how relatives preferred to be contacted, for example by telephone or by email. Staff had recently started to complete a weekly summary for people's relatives which provided an update on how their family member had spent their week. This included photographs and information on what activities they had taken part in.

## Is the service responsive?

### Our findings

Each person had a care plan; however not all aspects of the care plan had been reviewed regularly to ensure that the care and support they received reflected their current level of need. The registered manager told us they were in the process of updating people's care plans and that this was, "Clearly a work in progress". They had compiled a care records review action plan which detailed which documents were outstanding and what sections of the plan were due to be reviewed. From the action plan we saw that the registered manager had identified the care plans which were due to be reviewed and progress was being made to complete this.

Where people displayed behaviour which may be challenging they had positive behaviour support plans in place which detailed what behaviour may be displayed. The plans provided guidance for staff on how they should respond to behaviours displayed to reduce the likelihood of the person becoming upset. The plans detailed triggers and early warning signs and detailed early intervention strategies. The recovery phase, what is observed after the incident was also detailed alongside post incident strategies to support the person to calm. The service had an internal positive behavioural support team who visited regularly and reviewed people's behavioural support plans. The home also ran workshops which focussed on individual people to enhance the staff's understanding of how to respond to behaviour which may challenge.

We saw that where an incident had taken place this was recorded in the person's daily notes. Observation charts and incident forms were completed. This guidance allowed the staff to be proactive in understanding behaviour patterns and taking action to reduce this from escalating in future. However we saw that two people's positive behavioural support plans had not been reviewed or up dated. One had not been reviewed since May 2014; the registered manager told us that this document should be reviewed every six months. The positive behaviour support team were aware that this needed to be reviewed and had begun to carry out an assessment however there was no date for completion. This meant that people's care plans may not reflect the current care and support they required.

We also saw a behavioural support plan dated 12 September 2013. It had been noted that this was due for review and that the positive behavioural support team were to develop a new support plan however there was no updated information or date for completion. The registered manager told us the positive behaviour support team had visited this person and were in the process of completing an assessment of the support they needed.

We reviewed one person's care plan and saw that they had a, 'Now and next board' with a photograph of the next planned activity. We spoke with staff and they told us that this communication tool was not being used with this person; they felt it would be useful but were unsure when or why it was no longer used. The member of staff felt the person no longer needed the communication tool however the reasons for this were not clear. It was also not clear if an alternative communication aid would be beneficial. As communication tools were not being used as detailed in people's care plans the ability and opportunity for people to communicate was limited. The registered manager spoke with us about improvements they planned to make to the communication tools used. One person had recently started to use an application on their iPad

which they enjoyed using to communicate with staff. They told us it was about, "Finding ways for people to have their voice heard".

A relative raised concerns that their family member was not taking part in activities as detailed in their care plan. We saw that people's social needs were assessed and their care plan contained information on what hobbies and interests they enjoyed taking part in. Each person had a weekly activity record which showed which activities they had planned to take part in and what activities they actually took part in that week. We reviewed the weekly activity planner for one person from 28 March to 3 April 2016 and saw that they had planned to visit the local charity shop with support from staff twice that week; however this activity had not taken place. They had also planned to do home baking with staff twice that week and this activity had not taken place. They had taken part in their planned swimming activity with their mum with support from staff. The planner recorded that the activities listed were not being done on a daily basis. We reviewed the activity planner for another person from 14 March to 20 March 2016 and saw that they were not taking part in the activities as planned. They had planned to take part in swimming however this did not take place. They had planned for regular walks and one had taken place that week. A lack of stimulating activities for people with a learning disability can have a negative impact on their mood and behaviour.

The above information demonstrates that people's care and treatment did not consistently reflect their current needs or preferences and was not regularly reviewed. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager and they told us that they were aware improvements could be made in the activities people took part in. The registered manager and staff told us about the improvements they planned to make to ensure people's activities were personalised and meaningful. People had recently taken part in new activities including trampolining and adventure activities at a local forest.

We also saw examples of where people received care which was responsive to their needs. Care plans included information and contact details for people's key relationships. They also included information on people's health and social needs. Care plans contained information on people's life histories and likes and dislikes. People's care plans detailed their preferences such as what time they liked to go to bed and get up in the morning. People received care and support from staff who knew them and had an understanding of their life history. There was a section in each care plan which detailed the ways which people preferred to communicate. We reviewed one person's care plan and saw they had difficulties with verbal communication. There was clear guidance for staff on how best to communicate including, "'Do not overload me with lots of information; short concise sentences are better for me". From our observations staff communicated clearly and in a way the person they were supporting understood.

Daily records were kept for each person. They recorded which care the person had accepted or refused, what they had eaten and drank, and if there had been any changes to their mood. This ensured that the person's needs could be monitored and any changes responded to as needed. People also had a keyworker allocated to them who co-ordinated all aspects of their care and who reviewed their care plan with the person and their relatives. The registered manager told us they were trying to improve their communication with relatives and encouraging them to be involved in reviews of the support their family member received. In addition a member of staff spoke to us about the importance of ensuring people's relatives are involved and felt comfortable with the support their family member received, they told us, and "People's parents need to be reassured".

One relative we spoke with told us about a complaint they had made about the condition of their family members room and bedding. They also raised concerns that their family member was not involved in regular meaningful activities although they had not raised this as a concern with the registered manager. We reviewed the complaint record and saw that the registered manager had spoken with the family and new bedding had been purchased the day the complaint was raised. The person's bedroom was also tidied by staff. The registered manager had put twice a day checks on condition of rooms following complaint which involved staff checking on all aspects on the service including people's bedrooms to ensure that they were clean, tidy and any repairs needed were logged. There was a complaints policy in place and the registered manager told us how they would respond to a complaint. We reviewed the written records relating to complaints and saw that the registered manager had responded in line with the policy and recorded the details of the complaint, the action taken to resolve the complaint, who was informed and if the complaint was resolved. The registered manager told us they also had a meeting planned with the family members and social work to discuss previous and ongoing concerns. Staff demonstrated an understanding of how to deal with a complaint and told us they would take a note of the complaint and pass this on to the registered manager.

People were asked for feedback annually through a survey. The most recent survey had taken place in September 2015 and asked for feedback on topics such as the decoration of the premises, food, activities and staff conduct. People were given the option of being supported to complete the survey with support from their keyworker. Three people who lived at the service had completed the survey and the responses were positive. People were asked a selection of questions and could respond they were very happy, happy, ok or not happy/sad. People were also offered the opportunity to comment on the question. We saw that people were asked if they felt safe living at the service, all three answered and selected, "Happy" as the response. People were also asked for their views on the quality of the food provided, all three people answered they were happy with the quality of the food. Feedback had been requested from health professionals involved with the service and they were awaiting a response.



## Is the service well-led?

### Our findings

There was an effective management structure in place. There was a registered manager in post who was supported by a deputy manager. There was an on call system to ensure that a senior member of staff was available at all times. This was shared between the registered manager and the deputy manager. Staff told us both the registered manager and deputy manager were approachable and they felt comfortable raising any concerns they had with them. Staff were aware of the safeguarding and whistleblowing policy and told us they would report this to the manager if they had concerns. The manager valued their staff team and told us they ensured staff received regular supervision. Staff spoke positively about the registered manager and told us, "He's open and easy to speak to; he's got good ideas about the sensory room and communicating with family". Another member of staff told us, "He's easy to speak to and tries to solve any problems". One member of staff commented on the senior management team and told us that, "Expectations were not always clear".

Regular staff team meetings took place to allow staff to communicate their views about the care provided to people. Topics such as people's individual needs, safeguarding and support plans were discussed at team meetings. This provided opportunities to share ideas and provide feedback to the registered manager to ensure people's needs were met effectively. The registered manager focussed on supporting and encouraging staff to enable them to carry out their job effectively. The registered manager started in post in January 2016 and told us they had facilitated one to one sessions with each member of staff where they discussed the vision and values for the service and set up expectations on what they wanted to achieve.

Most relatives spoke positively of the registered manager and we were told, "The (registered manager) has made some really positive changes". However one family member felt their complaint had not been resolved appropriately. A meeting had been planned with the relatives, local social work department to discuss their concerns. Members of staff spoke positively about the registered manager, they told us, "There has been a dramatic change over the last few months, and it's been for the better". They also told us that staff morale had improved since the new registered manager had started.

The registered manager was able to describe the vision and values of the home. They told us their vision was, "To provide an environment that respects people and their preferences, I want an environment where people's preferences are at the centre, to build a person focused service". Staff shared the same values of the home and spoke with us about these saying, "We make sure we are showing equality, improving the guy's choices and making sure we are doing things in the guy's best interests, we try to focus on improving people's quality of life".

The registered manager spoke with us about the recent safeguarding concerns which included concerns about the maintenance of the premises. They told us that they had completed an action plan alongside the locality manager to ensure the concerns were responded to in a timely way. We reviewed the action plan and saw that concerns had been noted in relation to activities, care plans and maintenance of premises and action was being taken to address each issue. We spoke with the locality manager about the concerns and were told they were, "aware of the issues of concern at the service and were working with the manager to



resolve these and to improve quality of life outcomes for all." The registered manager felt supported by the senior management team in resolving the issue and told us, "They've been very supportive; the attitude is get the quality right and everything else will follow".

Checks were carried out to ensure that progress was being made to resolve identified concerns. The locality manager completed a check on the condition of the premises in March 2016 identified that decoration work was needed within the service. On the day of our inspection we saw that this work was underway and new flooring was now in the dining room and the walls of the communal areas of the service were being repainted.

Following recent safeguarding concerns the sensory room was in the process of being redecorated. We saw that new flooring and heaters were in place. At the beginning of the year sensory equipment had been bought to encourage people to use the room. Discussions had taken place with people about how to decorate the room and what theme to choose. Staff spoke positively about the improvements which were being made to the premises and the environment. They told us they were in the process of redecorating people's bedrooms to make sure they were personalised. They planned to use white canvas and encourage people to paint and decorate the canvases and display them on the walls. The registered manager told us they had the opportunity to visit other services which had been rated as outstanding to allow sharing examples of good practice. They planned to visit the services and identify ways to continually improvement the care and support offered to people.

Quality assurance systems were in place to regularly review the quality of the service provided. There was an audit schedule for aspects of care such as medicines, care documentation and infection control. Specific incidents were recorded collectively such as falls, changing body weight and pressure areas, so any trends could be identified and appropriate action taken. The registered manager carried out weekly and monthly checks including health and safety, fire evacuation and care records. The locality manager visited on a regular basis and checked the necessary audits had been carried out; they also produced a monthly report on the service. If a concern was identified the registered manager compiled an action plan and signed and dated each tasks when it was completed. When a concern had been identified the locality manager also followed this up with the registered managed when they visited. The outcome of audits and incidents and accidents were recorded electronically which allowed the locality manager and senior management team to review any concerns and ensure they were responded to in a timely way. Concerns relating to care records had been identified and were being addressed by the registered manager and also the locality manager. We have explored this in more detailed in the responsive section of the report. Environmental risk assessments were also carried out and there were personal evacuation plans for each person so staff knew how to support people should the building need to be evacuated. The provider's quality assurance team also carried out quarterly unannounced visits to the service.

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 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The registered person did not ensure that the care and treatment of service users was appropriate, met their needs and reflected their preferences.</p>