HF Trust Limited

Walberton (South Coast)

Inspection report

Freeman Close, Eastergate Lane
Walberton
Arundel
West Sussex
BN18 0AE

Tel: 01243542714

Date of inspection visit:
27 November 2017
30 November 2017

Date of publication:
28 February 2018

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

We carried out a comprehensive inspection of Walberton on 27 and 30 November 2017. The inspection was unannounced.

Walberton is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Walberton is registered to provide accommodation and personal care for up to 33 people with a learning disability across four properties. All of the properties were situated on the same site. The properties names were Melrose, Russett, Pippin and Fortune. At the time of the inspection there were 13 people living at Melrose, two in Fortune, 1 in Pippin and 10 in Russett. People living at the properties were all adults and there was a mix of younger and older adults across the service.

The provider ran a wood workshop and small apple juice production facility on the same site as the residential properties, along with a designated centre providing support with activities, which people could attend if they wished; these are not registered with the CQC as they do not provide any regulated activities under the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 and were not inspected.

Walberton has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. We found Walberton conformed to this guidance and values in their approach to supporting people using their service.

There were two managers in post who were both currently in the process of applying to be registered managers for the service. An operations manager was supporting the service and undertaking some registered manager responsibilities until the managers had been registered. A registered manager is a person who has registered with the 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.

We last inspected the service on 19 May 2015. At the previous inspection, we asked the provider to take action to make improvements as we found areas of the environment in all three properties were poorly maintained and not always clean which was compromising people's dignity and quality and life. At this inspection we checked to see if the provider had taken actions to address these issues and found this still required improvement.

Two of the three properties were not clean on the first day of our inspection. All three properties were in

need of maintenance works. The provider was aware of the outstanding maintenance work and a schedule of necessary repairs and improvements had been approved prior to our inspection and scheduled to take place.

The provider was not adequately assessing, detecting or controlling risks to people from infection and cross infection. Correct procedures for preparation and storage of food was were not being followed in two of the properties. Kitchens and the equipment in them was unclean. Hazardous waste was not always being disposed of correctly. Bathrooms and the equipment in them were not always clean.

Management of risks to the safety of communal and personal spaces and the living environment required improvement. Restricted cleaning chemicals were not stored securely. Health and Safety and fire checks and audits for communal and personal spaces at the service were in place, but were not being consistently completed at all three properties. Where checks and audits had been completed and issues had been identified as possible risks to people, no action had been taken to rectify problems.

There were assurance and information governance systems in place to monitor the quality and safety of the service. However, we found there was not always effective action taken in response to areas identified as needing improvement.

The service had experienced some historical under-recruitment since the last inspection. At this inspection we found that the service had enough staff to support people to stay safe and meet their needs. The service followed safe recruitment practices. Staff received safeguarding training and knew of their responsibilities to keep people safe from abuse.

Risks to people in their daily lives were identified, assessed and managed appropriately. People had risk assessments in place for activities particular to their choices and needs. Risk assessments were reviewed regularly and some were in the process of being updated when we visited.

The service was committed to making sure the people who used their service were encouraged and empowered to raise any concerns or issues they might have about abuse, including any abuse relating to people's protected characteristics under the Equality Act 2010.

Staff and seniors completed daily notes and accident and incident forms that allowed them to detail any concerns about people's safety. Incidents were reported onto other relevant agencies, which the service worked in partnership with to keep people safe. Systems were in place for reviewing and communicating learning with staff following safety incidents. Medicine support for people at the service, including obtaining, recording, storing, disposing and administering, was being managed safely.

The premises were easily accessible to people and included large communal living areas where people could spend time together if they wished. People's rooms were personalised to reflect their individual tastes and contained personal items, decorations and belongings. People had access to large outdoor areas if they wished to be outside. People were encouraged to have visitors and people's families and friends regularly came to the services.

The service was working within the principles of the Mental Capacity Act 2005 (MCA). Staff had received training in the MCA and knew how to put the principles into practice. People's consent to their care was sought and they, or appropriate people acting in their best interests, were involved in decisions about their care.

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 are called the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (DoLS) applications for people had been submitted. We checked to see whether any conditions on authorisations to deprive a person of their liberty were being met. For all of the people at the service none of these had yet been authorised. The managers were in the process re-applying for these on people's behalf.

Staff received an induction that met the Care Certificate standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve. Staff received training in subjects relevant to their role, including specific training to meet people's individual needs. The service used inter-organisation departments and outside agencies to provide on-going guidance and training in specialist areas, such as behavioural support. Staff received regular supervisions, one to one meetings and appraisals to support them to understand their responsibilities.

People had support to maintain good health and had access to healthcare professionals and services. Staff had a good understanding of people's health needs and monitored these appropriately. People had support to manage dietary or nutritional needs and were encouraged to be as independent as possible when preparing food and drinks. People had choice and control over what they ate and drank and when they did this.

Comprehensive assessments, often in partnership with other health and social care agencies and organisations, were undertaken to understand people's needs. People had support plans that reflected their needs. Staff supported people to achieve outcomes based on the needs and choices in their care plans.

People were supported with compassion and empathy. The service communicated in accessible and meaningful ways with people. Staff used people's preferred communication methods, including the use of technology, to enhance the delivery of care and promote people's independence.

People were actively involved in making decisions about their care and had expressed their views about how they wanted to be supported. The service promoted people's independence and privacy. We observed people were treated with dignity and people's confidentiality was respected.

People were assessed to identify their individual support needs and wishes and their care plans reflected this. Care plans were regularly reviewed with people. Where it was appropriate and with the person's consent, people's families or other health and social care professionals were involved in the review of people's care.

People were encouraged to follow their interests and achieve their life goals. People had individual activity plans and had support to access meaningful educational, vocational and social activities, both on and off the premises. People were supported to develop and maintain relationships with people important to them. The service was proactive about building strong links with the wider community to help people to do this.

The service provided accessible ways for people to understand and raise concerns. People and their relatives knew how to raise a complaint and felt confident to do so. Complaints were responded to appropriately and the service looked to learn from people's feedback to make any necessary improvements.

The organisation had a clear vision of people being at the centre of their support, with the service empowering them to realise their ambitions in life by giving them choice and helping them to take risks to

achieve their goals.

Managers promoted a transparent and supportive culture. Staff said they felt well supported. Staff had opportunities to contribute to ideas to help continually improve the service. Open communication was encouraged with people's relatives, and their feedback was involved in developing the service.

There were active forums for people at the service to raise issues, ideas and share information affecting, or relevant to, people with a learning disability - both inside and outside services. This feedback was taken to the highest level of the organisation and used to influence its strategic path.

During this inspection we found a breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The service was not adequately assessing, detecting or controlling risks to people from infection and cross infection.

Management of risks to the safety of communal and personal spaces and the living environment required improvement.

Risks to people in their daily lives were identified, assessed and managed appropriately. People had risk assessments in place for activities particular to their choices and needs.

Medicines were being managed safely. The home had enough staff to meet people's needs. Safe recruitment practices were being followed.

Staff received safeguarding training and showed understanding of their responsibilities to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Areas of the environment were poorly maintained and not always clean.

The service was working within the principles of the Mental Capacity Act 2005 (MCA). People had been supported to submit Deprivation of Liberty Safeguards (DoLS) applications.

People's consent to their care was sought and they, or appropriate people acting in their best interests, were involved in decisions about their care.

Staff received an induction that met the Care Certificate standards. Staff received training in subjects relevant to their role and had regular supervisions and appraisals.

People had support to maintain good health and had access to

healthcare professionals and services. People had support to manage dietary or nutritional needs and had choice and control over what they ate and drank.

Is the service caring?

Good

The service was caring.

People were supported with compassion and empathy.

The service communicated in accessible and meaningful ways with people.

People were actively involved in making decisions about their care and had expressed their views about how they wanted to be supported.

People's independence and privacy was promoted.

People were treated with dignity and their confidentiality was respected.

Is the service responsive?

Good

The service was responsive.

People were assessed to identify their individual support needs wishes and their care plans reflected this and were regularly reviewed.

People were encouraged to follow their interests and achieve their life goals and had support to access meaningful educational, vocational and social activities.

People were supported to develop and maintain relationships with people important to them. The service was proactive about building strong links with the wider community.

People and their relatives knew how to raise a complaint and felt confident to do so. Complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Effective action was not always taken in response to areas

identified as needing improvement from quality assurance and information governance systems.

Managers promoted a transparent and positive culture. Staff said they felt well supported and had opportunities to contribute to improving the service.

Open communication was encouraged with people's relatives, and their feedback was involved in developing the service.

There were active forums for people at the service to raise issues, ideas and share information affecting, or relevant to, people with a learning disability. People's feedback directly influenced the service's support strategy.

Walberton (South Coast)

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

This inspection took place on 27 and 30 November 2017 and was unannounced. The inspection team for the visit on 27 November consisted of three inspectors. For the visit on 30 November, the inspection team consisted of one inspector. In the two weeks following the inspection, two assistant inspectors made further phone calls to speak with people using the service and their relatives.

The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, due to technical problems we were unable to access the PIR prior to the inspection. Although we did not see the PIR before the inspection, we took the fact this had been completed into account when we inspected the service and made the judgements in this report.

We reviewed other information we held about the service, including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law, and enables us to ensure we were addressing any potential areas of concern.

During the inspection, we met with people living at the service. Assistant inspector's spoke with four people living at the service and four relatives on the telephone following the inspection. We spoke with four staff members, both managers and the operations manager. We 'pathway tracked' four of the people using the service. This is when we looked at people's care documentation in depth, and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

We observed the support that people received in the communal areas including lounges, kitchens and dining areas of the all three properties. We spent time observing how people were cared for and their interactions with staff and visitors in order to understand their experience.

During the inspection, we reviewed other records. These included four staff training and supervision records, staff recruitment records, medicines records, care plans, risk assessments, and accidents and incident records. We also reviewed complaints and compliments documents, quality audits, policies and procedures, staff rotas and information about activities people were supported with and provided by the service.

After the inspection, we asked the provider to send us copies of records relating to the management of the service and support for people. The provider sent these to us in the five days following the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Everyone said they felt safe where they were living and that the staff would keep them safe. A relative told us, "Yes, it is safe there". Another relative told us, "We feel very comfortable from that point of view" when asked if the service was safe. Despite this positive feedback, we found the service required improvement to ensure the safe prevention and control of infection and the safety of communal and personal spaces and the living environment.

Staff had received food hygiene training but we found correct procedures for preparation and storage of food were not being followed in Melrose and Russett. We found the fridges and cupboards in the communal kitchens were very dirty and contained food that was uncovered and unlabelled, as well as packaged food that was out of date. Bins in both kitchens were not covered and were unclean. Cupboards contained dirty and unwashed crockery and containers that were being used to serve and store food. Kitchen drawers were unclean, contained food waste and dirty cutlery. Drip trays under drying racks on the kitchen sinks were full of dirty standing water. The windows, floors, walls and surfaces of the kitchens were very unclean. We found accumulated food waste not collected in black bags lying on the ground outside of the back door of one of the properties.

Staff had received infection control training but we found although suitable bags, containers and disposal was available and in use for hazardous waste to help prevent and control the risk of infection, these measures were not consistently followed or enforced. Outside the kitchen at one of the properties, Personal Protective Equipment (PPE) and other personal hygiene cleaning materials had been thrown into an uncovered coal bunker by the back door and allowed to accumulate. The provider was not aware of this when it was bought to their attention.

Toilets in staff administration buildings and bathrooms and communal toilets in Melrose and Russett were not always clean. They contained dirty toilet brushes and bins containing personal care waste were not always covered. Posters advising on hand washing techniques, hand wash and hand drying towels were not always available for staff and residents in communal bathrooms and toilets, and several bathrooms and toilets had light pull cords that were heavily stained where people placed their hands to turn lights on or off. In staff administration buildings and in Melrose and Russett communal and personal living areas, internal and external windows and glass panels in doors were unclean and stained with fingerprints. Walls, carpets and flooring were stained and dirty. There were strong odours of urine in some communal toilets, hallways and in people's personal rooms that we entered. We did not observe these issues in Fortune Cottage.

All of the above examples meant people were exposed to an unacceptable risk of infection and cross infection that the provider was failing to adequately assess, detect and control.

At the last inspection on 19 May 2015 we identified an issue with cleaning chemicals not being safely stored and were accessible to people in one room. This was brought to staff attention and rectified on the day of inspection and the provider was not asked to take any further action. On the first day of our inspection 27

October 2017 cleaning chemicals assessed as requiring to be kept in a locked cupboard were found to insecurely stored and available to people in both utility and kitchen areas of Russett and Melrose, posing a risk to their safety.

Health and Safety, fire checks and audits for communal and personal spaces at the service were in place, but were not being consistently completed at all three properties. Where checks and audits had been completed and issues had been identified as possible risks to people, no action had been taken to rectify problems - in some cases for several months or more. This meant the provider was not doing all that was reasonably practical to mitigate risks regarding the premises that could affect the health and safety of people.

We raised these issues with the managers and the operations manager during the first day of our inspection. We were told there had been a lot of change with recent turnover of managers, staff and historical under-recruitment issues that had affected consistency and oversight of these tasks. One manager said, "Things slipped a bit" during this period of flux but now the staff and manager positions had been filled they were confident they could address this now they had these resources in place.

When we returned for the second day of the inspection we saw that action was taken to ensure the kitchens and bathrooms were deep cleaned, food storage and kitchen hygiene issues were addressed, hazardous waste was cleared and disposed of correctly and chemicals were stored securely. The operations manager sent us an action plan and examples of updated managerial audits in the week following the inspection detailing how they would be maintaining oversight with the managers to ensure actions were implemented and these areas of risk to people were managed appropriately moving forward.

Despite these retrospective actions, the provider had failed to ensure the safe prevention and control of infection and to do all that is reasonably practicable to manage risks to the safety of communal and personal spaces and the living environment. This is a breach of Regulation 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone said there were enough carers at the service to meet their needs. People's relatives gave us feedback that staffing levels sometimes varied when they visited. We observed two of the premises we visited on the first day of the inspection were short-staffed. This meant one person could not do the activity they had planned. We asked staff about this and were told this was due to last minute sickness, the service had not been able to arrange cover. Staff we spoke with told us staffing was generally sufficient, adding, "We've been down by one today but it's enough [to manage]". Another staff member said, "We can usually get cover and don't use agency, but not always".

The operations manager and managers told us there had been historical under-recruitment and high use of agency that had impacted on service delivery, but this had improved and the service was now nearly fully recruited. A person's relatives confirmed, "Yes there is enough staff – the service has taken on new staff". Another relative said, "It does seem to have improved lately regarding staff retention". We sampled rotas for each property for October and November 2017 and the managers explained how staff were allocated in accordance to people's assessed needs. We saw if there were no unexpected sickness issues, the rotas allocated enough staff to meet people's needs. Senior staff helped deploy staff for each shift with the right skills, experience and competencies for the people needing support.

All staff had to submit an application form, supply two references, a full employment history, complete a successful competency based interview and undergo a satisfactory Disclosure and Barring Service (DBS) check before commencing employment. DBS checks help employers make safe recruitment decisions and

help prevent unsuitable staff from working in a care setting. We sampled five staff recruitment files and found evidence all of these measures had been taken, keeping people safe.

Staff received safeguarding training and could demonstrate knowledge of their responsibilities to keep people safe from abuse. One staff member told us, "It is important to be observant, if someone had a bruise I would notice that and open up a discussion". They added if they suspected abuse they would, "Speak to a manager or notify a senior or I could call the on-call number. There is also a safeguarding number to call". Another staff member told us if they couldn't talk to one manager about an issue then they would speak to another manager, or the Police. Staff knew of the organisation's Whistleblowing policy and of the number to call to report poor practice and concerns over possible abuse.

Staff and seniors completed daily notes and accident and incident forms to detail any concerns about people's safety. Data from these sources was analysed and compiled into monthly 'Health and Safety Reports' to identify any themes, insights and recommendations to help prevent incidents re-occurring. Where applicable, incidents were reported on to other relevant agencies such as the local authority as safeguarding concerns. The managers worked in partnership with these agencies to ensure any necessary actions were taken to keep people safe. Systems were in place to allow for reviewing and communicating learning with staff following safety incidents. Managers said they regularly did this with their teams, usually during handovers or at meetings. Staff told us this was effective, saying, "You can see it works because it may lead to a new risk assessment or training being brought forward. Communication is one of the strengths here."

The provider had made protecting people and staff's equality and diversity rights explicit in their recruitment and on-going management processes. Staff were expected to value the diversity of, and show respect to, each person they support and to other staff members. The provider's recruitment processes ensured people could articulate this value and then provided on-going resources and support for staff to protect people as much as possible from discrimination or harassment. The provider took into account staff member's equality and diversity needs and made sure they took steps to protect them. For example, by facilitating flexible working arrangements for staff to respect their religious and cultural beliefs.

The provider encouraged and empowered people to raise any concerns or issues about discriminatory abuse or abuse that might cause psychological harm. Local hate crime co-ordinators from the Police had recently been invited to come and talk to people using the service about how to recognise hate crime and abuse from people purporting to be friends, or 'Mate Crime'. People had been told of their rights and how to report any concerns if this happened to them or people that they knew. People were given access to further resources in accessible formats to help their understanding about keeping safe from hate and mate crime. One person had spoken to a newspaper about hate and mate crime to help raise awareness of the issue and the impact this had on people with a learning disability.

Risks to people in their daily lives were identified, assessed and managed appropriately. People had risk assessments in place for activities particular to their choices as well as for their health and safety, physical environment and prevention of abuse. People had been involved decisions about their risk management support. Staff had read and signed risk assessments. Other knowledge about keeping people safe was relayed at handover, on daily notes and verbally between staff and management. Risk assessments were reviewed regularly and some were in the process of being updated when we visited.

We looked at the arrangements for managing medicines including obtaining, recording, storing, disposing and administering and found these were being managed safely. All staff had received medication training and responsibility for administering medicines was shared amongst the staff teams. We observed

administration of medicines to four people, which showed people were supported to be as independent as possible and their consent was sought. We checked Medicine Administration Records (MAR) and saw these had been completed appropriately. There were individual protocols in place for people who had medicines on a 'when required' (PRN) basis, which staff followed.

Everyone said staff supported them well with their medicines. We saw records detailing 11 medication errors occurring at the service in the last year. Four of the errors had occurred in the last two months. We discussed this with staff and the managers. We were told of measures the service had taken and put in place, such as extra staff training, additional observations, along with re-configuring ordering systems and more stringent management checks of stock control, to help ensure people received their medicines as intended and future errors were minimised further.

Requires Improvement

Is the service effective?

Our findings

At the inspection in May 2015, we asked the provider to take action to make improvements as we found areas of the environment in all three properties were poorly maintained and not always clean. This meant people were living in an environment that did not fully promote their dignity or offer them the best quality of life. This was a breach of Regulation 15 – Premises and Equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we checked to see if the provider had taken action to address these issues and found this was an area that still required improvement.

The provider had submitted an action plan in July 2015 outlining what they would do to meet the regulation. Several actions on the plan regarding improving the environment had been met, including remedying damaged plasterwork and replacing window frames. However, we found the overall physical environment across all of the properties to be poor. Throughout each property in kitchens, bathrooms, hallways and communal and personal living areas, decoration and refurbishment was required and fixtures and fittings were in need of replacement. The operations manager and managers acknowledged and was aware of the need for maintenance work and the operations manager showed us a programme of works to completely replace kitchens, bathrooms, flooring, windows and doors and carry out decorations across all three premises that had been agreed prior to the inspection to start in November 2017.

We looked at actions the provider had told us they were going to take to make sure the service was clean. An action on the plan to install extraction units to address offensive odours had been completed. However, this action had not been effective and other actions that were to be taken to ensure the service remained clean, including implementing and overseeing cleaning schedules, had not been maintained.

We brought these issues to the attention of the operations manager and managers during the first day of the inspection. We were told turnover of staff and historical under-recruitment issues had affected ability of staff to maintain consistency of domestic support tasks in the two larger properties. Managerial oversight had also been affected by changes to managers over the last year.

When we returned on the second day of the inspection, all three premises had been deep cleaned. The service did not employ cleaning staff but the operations manager was now considering recruiting in this area to ensure expected standards of cleanliness were maintained. Following the inspection the operations manager sent us an action plan detailing adaptations to existing tasks and checks for staff and more frequent and comprehensive on-going audits for managers to ensure the premises were kept clean and people's dignity and quality of life was not being compromised.

There were large communal living areas where people could spend time together if they wished. People's rooms were personalised to reflect their individual tastes and contained personal items, decorations and belongings. People had access to large outdoor areas if they wished to be outside and there were benches for people to sit. There was a sensory garden where herbs were growing and there were plans to develop some allotments. People were able to freely access the activities centre, wood workshop or be part of the apple juice production on the site, which included a large orchard, if they chose. As well as the activities on

offer, these places offered a chance for people who lived in different premises the opportunity to spend time together. Several people chose to visit the office administration building and sit with the staff working there and did this frequently. People were encouraged to have visitors and people's families and friends regularly came to the services.

The Mental Capacity Act (MCA) 2005 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.

We checked at this inspection whether the provider was working within the principles of the MCA and found that it was. Staff had received training in MCA and understood how to put the principles of the MCA into practice. One staff member told us, "Every day practice is based on individual rights and mental capacity awareness. We assume capacity and fill in with support where people need and accept it". Another staff member said there were "different levels of capacity" and that it was important to give people "as much freedom as possible" to be able to make their own decisions.

People told us staff sought consent before doing a task and involved them in decisions if needed and we observed this to be the case throughout our inspection. One person told us, "I do things myself", another person told us that "staff do involve me in things". The staff ensured that if people lacked capacity to make a decision they supported them to involve the relevant people in a best interest process. People's care plans contained a clear assessment of their mental capacity and it was documented that they, or an appropriate person had consented to their care, and that this was expected to be regularly reviewed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in line with their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted by the previous registered manager for all of the people at the service. However, none of these had yet been authorised. The managers were in the process re-applying for these on people's behalf.

The managers told us the service completed comprehensive assessments, often in partnership with other health and social care agencies and organisations, before people moved in. This process was designed to really understand who the person was as an individual and then build a support plan that achieved effective outcomes. One relative told us the service had worked with their previous support agency to share information regarding [Name's] needs and strengths when they moved into the service and this had been effective as now, "The service very much meet's [Name's] needs".

The provider took steps to ensure that people were protected from discrimination when making care and support decisions. Equality and diversity operational standards were available for staff. These standards included best practice guidance regarding communication in line with the Accessible Information Standard, supporting transgender and other protected characteristics of people in line with the Equality Act 2010 and respecting people's consent and decision making rights.

Staff told how they put equality and diversity standards into effective practice. For example, by using people's preferred communication methods, such as Makaton and pictorial signs, to help them to understand and consent to their care and achieve the outcomes they wanted. Staff also used technology to enhance the delivery of care and promote people's independence. One person had been finding aspects of verbal communication a challenge and had not always been able to finish sentences when talking to

people. Staff supported them to use an application on their phone that gave the person prompts to finish sentences they had started, so they could do this and say what they wanted when talking to people.

Staff had an induction that met the Care Certificate Standards and had a two week shadowing period before they started lone working. A relative told us they felt the induction had been effective for newly recruited staff, "There are some new staff at the moment and I have chatted with them – I feel that staff have the right skills and are competent". The provider gave staff on-going supervisions, training and appraisals to give them the right skills and knowledge to be able to deliver support to a high standard. There was a staff development programme that allowed staff to progress with their learning and experience in different aspects or their current roles or take on new roles within the service. The service supported staff to complete level 2 and 3 Qualifications and Credit Framework (QCF) Health and Social Care qualifications. We sampled staff training and supervision records and saw that staff training was up to date and supervisions and appraisals were taking place regularly.

Staff spoke highly of the training and supervisions, one staff said, "Training has been all I could want", another staff said, "Support to staff is brilliant. You get all the training". The provider offered bespoke training if a person had a particular need, such as epilepsy or dementia so staff could offer them the best support. The service had an internal 'Specialist Skills Team' that had recently been to the service to deliver Positive Behaviour Support (PBS) training. PBS is a British Institute of Learning Disabilities (BILD) accredited training method that supports people to manage behaviours that might challenge. We saw people with behavioural needs had detailed care plans outlining preventative strategies and proactive ways to support them in the least restrictive and most person centred manner possible.

The provider took steps to be flexible with offering training to staff in order to support people with learning disabilities to exercise their human and societal rights and avoid discrimination. For example, one staff member told us they had last week attended a training course on sexuality and learning disabilities with other staff.

People had keyworkers who were responsible for helping them to achieve specific individual support outcomes they needed or had chosen. All people we spoke to answered, "Yes" when asked 'Are staff well matched for you?' All four people then gave details of their keyworker and how they had helped them access their chosen hobbies and interests.

People told us they had enough to eat and drink and the food was, "Good" and, "Ok". People were involved in their support with eating and drinking and we saw people were encouraged to be as independent as possible. We observed lunch where we saw people making their own food with minimal supervision. People mainly made sandwiches and ate them where they chose. The lunch was calm and unrushed, people either ate together or alone before going onto activities after they had finished eating. The evening meal menu showed the individual who had chosen the meal that day. The manager told us people were asked individually to make these choices. They had been subject of house meetings but she said experience was that the individual approach was more successful. There was always an alternative to the main meal if anyone did not want to eat this. Staff explained people needed more support with cooking meals to ensure their safety, but were still involved as much as possible. One person told us, "Staff help but let me do some myself". Relatives told us, "[Name] helps cook the meals – it makes [Name] feel special".

People had appropriate support with any dietary or health related food and drink needs, for example one person was prone to putting too much food in their mouth posing a risk of choking. We were told by their relative, "The staff know this and help [Name] with eating and they monitor her when she is feeding herself". People's care plans and risk assessments accurately recorded support people needed and included

guidelines from speech and language therapists regarding managing risks of choking and dietician advice on nutrition. The service helped promote healthy eating and good nutrition with people, giving advice over portion size and advising people not to eat too many sugary snacks. One person had a gluten-free diet and staff supported them to make sure this need was met.

People were supported to access healthcare services and receive appropriate on-going health care support. Relatives told us, "Staff help [Name] with all medical appointments – they organise them; go with them; wait with them and bring them back. It all works well". All people had support to have an annual health check and people's health was routinely monitored to make sure their healthcare needs were met. Staff told us they were proactive in making sure referrals were made quickly, saying, "We always insist on GP attention if we are concerned and they trust our judgment; if someone needs antibiotics they will have started them before the end of the day, if they need a paramedic we will get one."

People's care plans showed records of health care appointments were kept and showed evidence of people who had been supported with referrals to appropriate health services. For example, one person had been noted as appearing to lose weight. Records showed they had been supported with a referral to a dietician and the dietician recommendations were subsequently included in an updated support plan. Records also showed dietary advice was being followed by staff. Another person with emotional and behavioural needs had been supported with a referral to a psychiatrist that they saw regularly and whose advice was incorporated into their care plan.

Good

Is the service caring?

Our findings

People said they thought the service was caring. People's relatives told us they thought the service provided kind and compassionate support. One relative told us, "Staff do treat people very well". Another relative said, "Staff are caring – I have never observed otherwise and I have been going in and out of there for 20 years". One said, "I was touched by the effort the staff put into the job, including on their own time." We were told by other relatives that, "Staff talk things through with people" and there was a, "Good rapport" between people and staff. We observed this to be the case. People were relaxed in the company of staff and talked and laughed easily when having conversations or interacting with them.

The staff communicated in accessible and meaningful ways with people. This included taking into account any protected and other characteristics under the Equality Act 2010 where appropriate. Easy Read copies of all policies and procedures were available for people whose ability to read was limited by their learning disability. Care plans contained detailed pictorial guidance for tasks and activities for a people who communicated non-verbally. One person had a 'Supporting me to get dressed' plan. The plan included an annotated pictorial guide the person could use to show staff what was important to them in appearance and comfort when they were doing certain activities. This helped the person to choose the right clothes for the day. Other people had pictorial aids they used to create plans for activities they wanted to do for the week, which they could then reference and understand independently to remind and be reassured about their up-coming schedule.

One person was hearing impaired and preferred to communicate using a mixture of Makaton and unique signs. The person's care plan clearly detailed this information. We observed the person using their signs to indicate a need and staff responding and communicating with them using their preferred signs. Pictures and objects of reference were also used to communicate with and allow the person to indicate their choices, such as showing them a picture of a swim suit to suggest going swimming. The person had a detailed communication book titled 'All about me.' This included information about how the person liked to be supported and their personal likes and dislikes. The book was full of pictures relevant to the person and these were used in a 'Now and Next' format to help staff engage with the person, understand their preferences and plan their support as they chose. We observed this person using their communication book to engage with staff.

Staff told us the service provided information and training about the social history of people with learning disabilities during their induction to help them develop a compassionate and empathetic approach when supporting people at the service. Staff said this was useful as it helped them to understand more about the context of some people's personal history and background and how this had been a part of shaping the people they were today.

People told us they felt actively involved in making decisions about their care and had expressed their views about how they wanted to be supported. They were individual monthly meetings between people and their keyworkers and house meetings where people could express their views on their support. People told us, "[we are] able to be as independent as [we] want". A relative told us the service, "Does promote

independence".

Where people had expressed particular preferences for support the service took steps to accommodate this. For example, one person was recorded as preferring female only support with personal care, and this was arranged on the service rota. This preference was also clearly recorded in the person's care plan, followed by precise guidance to how the person liked to be supported with personal care. The plan contained an emphasis on maximising the person's independence throughout this task.

People told us their privacy and dignity were respected. Staff we spoke with understood the importance of promoting and respecting people's privacy and dignity needs. One staff explained they always took steps to uphold this while delivering personal care support to people saying, "I always ask if it is ok [to give the support] and seek permission. Always use people's name and ask questions as you go to see if they are comfortable and give them choices". People's relatives confirmed staff respected people's privacy and dignity. One relative said, "Staff knock on doors and wait before entering, we have witnessed this". Another relative said, "Staff respect [Name]'s privacy, they don't give personal care in front of relatives or others. Staff wait outside the toilet door when taking [Name] to the toilet".

Staff supported people in a dignified and respectful manner. One person was upset on one of the days of our inspection. Staff gave the person time and space to express themselves, before enquiring after their welfare calmly and gently taking time to listen to them before responding. This approach helped to de-escalate the situation in a compassionate but dignified and respectful manner. The person was able to explain more clearly what their issue was and staff then helped to resolve this to the person's satisfaction.

The provider had a flexible approach to supporting and promoting people's independence and privacy. A young adult at the service had recently moved in after living at home. The service was working in partnership with the person and their family to manage the transition. This was being managed carefully, but was working well and small but significant steps were being taken to promote the person's right to independence and privacy. For example, changing the address of the person on their GP records – so the person's medical correspondence was sent directly to them at the service instead of going to their parent's address first.

The staff actively encouraged people's relatives and friends to visit people whenever they wished. Relatives told us they got on well with staff and were made to feel welcome. Staff told us they followed the service confidentiality policy and respected people's privacy, saying, "You don't say anything to anyone unless you need to, it is not necessary to talk about [people's private information] unless people need to know about it". A relative confirmed that in their opinion the staff and service, "Are very confidential".

Good

Is the service responsive?

Our findings

People told us they felt their choices were respected and their needs and wishes were reflected in their support. A relative told us, "When [Name] first moved in their needs and support were assessed and planned [by the service]" and they felt, "Current support meets [Name]'s needs and choices – staff always do everything within their capabilities/resources [to meet these needs]". We were told by another relative that, "When [Name] moved in staff took lots of notes about [Name]'s likes, dislikes, needs and strengths" and they felt, "The staff fully understand [Name]'s needs". The manager's told us the service took a lot of time with their assessment process, involving the person, their family and any other relevant people to make sure this resulted in truly person centred care for people.

The provider had gone to significant lengths to deliver support that gave people the best possible quality of life. The top floor of Melrose had recently been converted to a self-contained flat to allow for two younger adults who wanted to leave home to move into an environment more suited to their strengths and levels of independence. There were future plans to do the same for Russett, based on this being a success at Melrose.

The operations manager told us of an outline proposal to reconfigure the downstairs of Russett into two separate buildings in order to better accommodate the physical, mental, emotional and social needs of people who lived there with early on-set dementia, whose needs were changing. People had lived at the service for a long time and a move away to a more specialised service was not their choice and was detrimental to their social relationship circles and emotional health. The provider was willing to invest the resources to make staying at their home in a familiar environment possible, to ensure people's quality of life was affected as little as possible while their support needs evolved.

People's care plans reflected the support needs and wishes identified in people's assessments. Care plans were regularly reviewed every six months with the person. Care plans were also reviewed sooner if a person's needs and wishes changed. All four people we spoke with said they had gone through their care plan with their keyworker. We saw examples of a care plan being reviewed following experience within the service that led to staff identifying the significance of certain words and phrases a person often used. This had resulted in the plan now detailing effective responses to these words and phrases and had improved communication and engagement between the person and staff.

Where it was appropriate and with the person's consent, people's families or other health and social care professionals were involved in the review of people's care. This multi-agency approach had been productive in ensuring people had the best support outcomes according to their specific individual needs. For example, we saw meeting minutes that detailed a recommendation from a Speech and Language Therapist to implement a specific communication technique for a person. This had been done and had resulted in an improved, more interactive PBS plan.

In addition to specific and detailed sections on certain support needs, care plans we sampled contained a document entitled 'Things you need to know about me' as well as a 'Personal Routine Easy Access Sheet'. These documents provided a summary of people's likes and dislikes, personal history, important people

and things in their life and their personal strengths and areas where they needed more support. This information was easily accessible for staff and helped them to understand and respect people's choices as the individuals they were, and to then offer appropriate support. People's relatives told us, "Staff know a lot about [Name] and his personal and family history" and felt this helped staff understand their needs. Staff gave us an example of how they used social and personal information to offer support that was meaningful to people. One staff member told us about how when they took people on holiday, they made sure it was to "Where it is relevant to them, to follow their interests or link to their family history". We were told similar information in care plans helped to ensure people's cultural and religious needs were respected, for instance a person of Asian origin had support to celebrate the Chinese New Year and other people of Christian denomination visited the local church.

People were encouraged to follow their interests and achieve their life goals. One staff member told us, ""The service is about supporting people to live the life they want…their lives aren't decided for them. We encourage them to find ability, e.g. if they want a cup of tea, the starting point is to support them to do it themselves". The staff member added the service "…encouraged people to try more". The staff member gave the example of how for one person this led to staff and the person, "learning, that the person can be involved in handling money and receipts, which the person had previously been thought not able to do.

People had individual activity plans and for some people this included support to access other support services that offered educational and other activities. Other people had support to access activities both on and off the premises with staff support, in line with their preferences. The service made full use of their on-site apple juice production and woodworking facilities to offer meaningful social activities to people. One relative told us, "They have woodworking classes too and [Name] is good at packing firewood, which she likes doing". A staff member told us about a person they supported who used the woodworking shop to make artefacts with personal reverence and emotional significance for them. This acted as a creative outlet for the person to be able to express their feelings.

The operations manager told us the juice production was run as a social enterprise and both people at the service and other people worked there as unpaid volunteers. We were told people mainly volunteered who did not meet the criteria for local authority funding for the activities centre and were interested in the activities more suited to their abilities that the juice production facility could offer. This also gave people the chance to gain transferable workplace skills. A relative told us, "[Name] delivers apple juice, helps with bonfires and is going to be assessed for driving the sit-on lawnmower".

The service comprised of several buildings on a self-contained site, in large grounds and physically located away from the centre of the small village it was located in. The operations manager explained the service was very, "Forward facing" to avoid the risk of perpetuating any social isolation people who lived there might feel or experience due to the physical barriers posed by the self-contained site and location. The operations manager was also keenly aware of the social isolation people might experience as a citizen with protected characteristics, due to having a learning disability. For these reasons, the service was committed to encouraging and supporting people to develop and maintain relationships with people important to them and within the wider community.

The previous and current managers and the operations manager were proactive in building strong links with the village in which it was situated. One person volunteered at the local church and several people often went to religious and other events there. The service also regularly held fundraising and other events on the premises which were well attended by people from the local community and beyond. One of the main events was an all-day music festival on the premises that had been running every summer since 2016. This event was specifically designed to raise awareness of people with learning disabilities within the general

public. A local newspaper report about the festival quoted the previous registered manager as describing one of the main objectives of the festival as being, "To involve people at the service with the public and the public with people at the service". This event had been successful and was scheduled to happen again in 2018. A sensory garden project had taken place involving volunteers from local schools coming in regularly to help people build and maintain it. Other projects the service had undertaken to raise funds and awareness for people with learning disabilities included a trek in five day trek in Iceland being undertaken one of the people at the service, with staff and volunteers support.

The service had built links with an Art Gallery in a nearby city, where people regularly went to participate in arts courses and programmes. People went to a local amateur dramatics club to take part in drama classes and productions. There were social clubs in nearby towns and cities that the service supported people to attend, where they could take keep fit classes and go to discos if they chose. The service also hosted discos. The service supported people with a learning disability who were not part of the service to volunteer to work there, one of the volunteers had recently attended a recognition tea party at Buckingham Palace to thank them for their efforts.

There was a written formal complaints policy and procedure, which was shared with people and their relatives. Alongside this, the service had a 'Making Things Better' form which provided information for people about how to say if they had concerns or complaints in an accessible format. People we spoke with said they, "Felt happy saying if they were unhappy about anything" and knew how to raise a complaint if they needed to. People told us they, "Tell staff if any problems or keyworker, or manager if needed". People's relatives told us they, "Can always raise concerns if I wish." Another said they were, "Confident to talk with staff about complaints and have knowledge of which staff to escalate complaints to" as well as being, "Confident to find out how to formally complain 'externally'" if needed.

The managers logged all complaints and concerns centrally onto an electronic system. We saw evidence that complaints and concerns raised had been responded to appropriately and in line with the company policy. The operations manager completed a report for senior management based on complaints received. This was reviewed to look for ways in which the service could learn and improve from the feedback they had received. We saw an example of this, where it was reported some staff were, "Not seeing complaints as a learning experience" and the service was taking measures to improve accordingly.

There were no people at the service currently receiving end of life care. The managers were taking measures to explore putting in place formal end of life care plans for people. This process was involving family members if appropriate. For people lacking capacity, a best interests meeting was being arranged to ensure they had support to record their preferences and choices regarding end of life care and have a comfortable and dignified death. One relative said, "The home is good at discussing end-of-life wishes" and, "The home will be good at supporting us with this". We were also told that the service was very good at offering appropriate emotional support to other people using the service and their families. A relative said, "Staff were very good" at this in their experience.

Requires Improvement

Is the service well-led?

Our findings

There were two managers in post who were both currently in the process of applying to be registered managers for the service. An operations manager was supporting the service and undertaking some registered manager responsibilities until the managers had been registered. There were assurance and information governance systems in place to monitor the quality and safety of the service but we found there was not always effective action taken in response to areas identified as needing improvement.

Staff completed daily routine task sheets to record basic tasks, such as personal care support and cleaning of the environment. Staff completed regular daily notes for each person about their support. These notes were uploaded onto a centralised electronic system that alerted staff to risks, goals and outcomes and important dates and appointments. Notes and daily task sheets were audited by seniors or managers. Spot checks were carried out to assess practice by senior staff and managers. Managers were expected to complete monthly audits and reports and put actions in place as necessary to address any issues, or build on any success as a means to drive continuous improvement. The service was audited based on reports compiled from these sources every month by the operations manager, which was then shared with senior managers for review and further actions and recommendations.

We sampled quality audits and records that showed issues had been identified that were affecting service quality and safety. However, improvements were needed to ensure the service took timely action to sustain continuous improvement where quality and safety was being compromised. We discussed the delay in actions being taken in relation to issues such as poor standards of infection control and health and safety management which were evident during the inspection. The operations manager acknowledged the frequency and effectiveness of quality assurance audits and actions had been affected by recent turnover of staff and management, which in turn had impacted on service quality. The operations manager sent us information following the inspection detailing how they and the managers would be more active in monitoring service quality, to make sure quality standards were sustained at an acceptable level.

The managers were committed to creating an open positive and person-centred culture at the service. One manager said they aimed to support staff so they could, "Make a difference from the start of their training". Another manager told us they encouraged communication between staff and management as a way to encourage transparency and honesty, as well as making sure they were always approachable and even working alongside them to carry out support worker tasks if necessary. Another manager said, "I like to make myself visible" and told us they made sure this meant not working in the office building exclusively. The operations manager was also based on-site and made sure they contributed to the positive culture. All four people we spoke with said the operations manager, "Was nice". A staff member said "I feel respected… it is easy to talk to all the managers. I don't have to worry".

Team and management meetings took place at least every three months. We saw challenges, concerns, risks and achievements had been recorded as being discussed with the team, with an emphasis on finding solutions in order to improve the quality of life for people using the service. Staff told us, "…We can bring

everything to the table". Another staff member said, "I raise issues and question about what we could do differently". Another staff said, "I am comfortable to question practice if I need to". A staff member told us that there had been issue within the team in the past and at times, "It could be better" but this had been discussed and they acknowledged, "There are different ways of working. The managers are aware [of team issues] and we are working on improving it". Other staff said, "We all pull together to make sure people get support".

The organisation had a clear vision of people being at the centre of their support, with the service empowering them to realise their ambitions in life by giving them choice and helping them to take risks to achieve their goals. Staff we spoke to showed a good understanding of the overall service vision and were engaged in delivering this vision. One staff member told us, "Our support is person centred to the highest level. We give people what they want to lead fulfilling lives, we don't want them to be held back because they have learning disabilities".

The provider ran a leadership development training programme for senior staff and managers, to help them to be able to lead and support their teams to deliver high quality support in line with the service vision. Both managers at the service were currently under-going this training. The operations manager had been undertaking registered manager responsibilities to support them while this training was taking place. There were clear operational standards outlining expectations for staff responsibility and accountability. We saw these standards were positively enforced via management processes such as supervisions, appraisals and disciplinary and probation procedures. Staff told us they were well aware of what was expected of them due to the management processes, "Supervision with [Name] is always very good and always ends with setting a date for the next one, it's seen as important. Then we get monthly staff meetings and emails so we are well informed". Staff told us feedback from managers was, "Helpful" and, "Useful". One staff said the managers made sure, "I know what I am doing well and where I can improve".

The operations manager told us staff equality and diversity requirements were respected via the service recruitment procedures and then had on-going management and human resources support. Service staffing policies outlined there was a free Occupational Health Service and advice and counselling support line to support staff with work or non-work related physical or emotional health issues.

People told us they had reviews with their keyworkers to help them say how the service could develop. We saw minutes of monthly house meetings that had been printed accessibly, discussing topics such as, 'What could we change about your home' and, 'Things you're not happy with'. Minutes recorded actions to be taken in response to feedback, but we did not see evidence of how these had been followed up. Staff told us they were actively involved in the development of the service. One staff member told us, "We even share support ideas for individual service users. I've already said we should do something special for the remembrance celebrations next year and have got the go-ahead. It's something we worked on with people this year." Another staff member said, "We received an email from management last week asking for ideas on how to improve the quiet room in Russett".

The service looked to enable open communication with family members, who were seen as key stakeholders. The operations manager explained the service worked hard to be open and transparent with families about service delivery. Relatives told us the operations manager was, "Approachable…I am confident to talk to them about anything". Other relatives said they had been made aware of issues such as high turnover of staff but that the operations manager had been, "On the ball" and, "Especially recently the service has been trying to improve". Regular newsletters and correspondence from the service were sent to keep people up to date about wider service and organisation information. Surveys were sent out to family members asking for their involvement in developing and improving the service. These were then reviewed

by management and actions taken in response to the feedback. We saw examples of service responses to feedback from families that included reviewing activities and getting involved with the wider community.

The service was part of a larger organisation that ran a scheme called 'Voices to Be Heard network' which held local, regional and national forums. These forums were for people supported by the organisation to raise issues, ideas and share information affecting, or relevant to, people with a learning disability - both inside and outside services. This feedback was taken to the highest level of the organisation and used to influence its strategic path. Priorities that had been identified and taken into account and supported across the organisation included; increased use of technology to assist people with learning disabilities, better communication between staff and people, support to develop relationships and support to find employment.

There were regular local 'Voices To Be Heard' forums at the service, and we saw copies of accessible minutes where people offered ideas and suggestions about how the service could develop locally and nationally. A person at the service had recently been elected as a regional representative to take feedback to the national 'Voices to be heard' forum. The person had attended meetings at the organisations' head office to do this and had met her Royal Highness the Princess Royal to talk about the scheme and issues it raised. Feedback from 'Voices to be Heard' meetings was also taken to lobby support for political change on a national level. The representative at the service had recently been supported to go to a meeting at the House of Commons to talk to the chamber about the impact of universal credit benefit reforms on people with a learning disability. This had been widely reported in national press and had helped to raise awareness about the impact this would have and the protection from further disadvantage that was needed, from the perspective of an already marginalised group within society.

There was specific training for registered managers to help them understand the requirements of this role. Care homes and other health and social care services are required to notify the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check the action the service took and if necessary request additional information regarding about the event itself. The operations manager had submitted notifications to the CQC as required regarding all notifiable events that had occurred at the service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service and on their website where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the service had conspicuously displayed their rating in the office building's entrance hallway, along with a copy of the last inspection report, and displayed the ratings via a link to their service on the organisation's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) (2) (b) (d) (h) Failure to ensure the safe prevention and control of infection. Failure to do all that is reasonably practicable to mitigate risks to the safety of communal and personal spaces and the living environment.