New Directions (Robertsbridge) Limited

Bishops Croft

Inspection report

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Date of inspection visit:
25 April 2017
26 April 2017

Date of publication:
21 June 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Bishops Croft is a care home providing residential care for up to eight people with Prader-Willi Syndrome. This was an unannounced inspection which took place on 25 and 26 April 2017.

At a comprehensive inspection in February 2016 the overall rating for this service was Requires Improvement with four breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 identified. We asked the provider to make improvements to ensure care and treatment met people's needs and reflected their preferences. Systems and processes needed to be improved to enable the provider to assess, monitor and improve quality of services and ensure that accurate, complete and contemporaneous records were in place for each person. The provider needed to ensure that a system was in place to review risks based on people's individual needs and ensure staff were appropriately trained and supported to enable them to carry out their role safely. Improvements were needed in relation to consent and decisions around Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider sent us an action plan stating they would have addressed these breaches of regulation by June 2016. At this inspection we found that although some improvements had taken place one new breach was identified. A recent change to the structure of the organisation meant that some new systems needed time to become fully embedded into practice.

Bishops Croft did not have a registered manager in place. An acting manager had been in day to day charge. Implemented changes needed clear provider oversight to ensure they were fully embedded into practice.

Individual risks to people were not always identified to ensure people remained safe at all times. This included risks identified in relation to how peoples care was managed. Staffing levels at night did not demonstrate how people would be safe in the event of an emergency evacuation.

A training programme was in place to support staff, although information was needed to show how staff who needed support to complete training had this provided. Inductions for new staff were in place. The supervision programme had fallen behind but staff felt that they were supported and able to speak to the acting manager if they had any concerns.

People felt involved in choices and day to day decisions, however, Deprivation of Liberty Safeguards (DoLS) systems needed to be further improved to ensure that this was consistently effective and corresponding information recorded in care files.

People had keys to their own rooms and their personal space was respected. Staff needed to be aware not to have discussions regarding peoples care and support needs which may be overheard to ensure their privacy and dignity was maintained.

Staff knew people well and displayed kindness and compassion when supporting them. People were encouraged and supported to remain as independent as possible. Activities were varied and a weekly

programme was available for people. People told us they were able to do the things they enjoyed. Care documentation been updated to make it more person centred. However further improvements were needed to ensure all information was reviewed and updated.

Systems were in place to manage people's medicines and people told us they received their medicines at the right time. People were supported to have access to other healthcare professionals and organisations if needed and staff assisted people in making and attending appointments.

People were involved with changes in the menu and meal choices. People told us they were happy with the standard of food provided. People's weights and nutrition were monitored regularly to ensure dietary requirements were reviewed if required.

Staff were aware of how to recognise and report safeguarding concerns. And notifications had been completed to CQC and other outside organisations when needed.
Systems and equipment used within the home, including gas, electrical and water systems were monitored and serviced as required.

A complaints policy was available. Information regarding how to make a complaint was displayed. Staff and service user meetings took place and feedback was sought from people.

We found one breach of the Regulations of 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 the full version 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

Bishops Croft was not consistently safe, although some improvements had taken place a further areas of concern were identified.

Individual risks to people were not always identified to ensure people remained safe at all times. Accident and incident recording needed to be more robust.

Risk assessments and plans to manage identified areas for staff support were not in place. Staffing levels at night did not demonstrate how people would be safe in the event of an emergency evacuation.

Systems were in place to manage people's medicines and staff were aware of how to recognise and report safeguarding concerns.Systems and equipment used within the home, including gas, electrical and water systems were monitored and serviced as required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Deprivation of Liberty Safeguards (DoLS) systems needed to be further improved to ensure that this was consistently effective. People were involved in day to day decisions and their decisions respected.

A training programme was in place. Structured management plans were needed to show how staff with support needs completed training.

Inductions for new staff were in place. Supervision was scheduled to take place every six weeks for all staff. However, this had fallen slightly behind but the programme was on-going.

People's nutrition was managed and reviewed.

People were supported to have access to other healthcare professionals and organisations.

Is the service caring?

Requires Improvement

Improvements were needed to show the service was consistently caring.

People's privacy and dignity were not maintained at all times. Staff needed to be aware not to have discussions regarding peoples care and support needs which may be overheard.

People had keys to their own rooms and their personal space was respected.

Staff knew people well and displayed kindness and compassion when supporting Them.

People were encouraged and supported to remain as independent as possible.

Is the service responsive?

Requires Improvement

Further improvements were needed to ensure the service was consistently responsive.

Care documentation been updated to make it person centred. However further improvements were needed to ensure all information was reviewed and updated.

Activities were varied and a weekly programme was available for people.

A complaints policy was available. Information regarding how to make a complaint was displayed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was no registered manager at Bishops Croft.

On-going changes needed clear provider oversight to ensure they were fully embedded into practice.

Improvements had been made to support staff and improve morale.

Staff and service user meetings took place and feedback was sought from people.

Notifications had been made to outside organisations and CQC

when needed.

Bishops Croft

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 April 2017 and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and information and notifications which had been submitted by the home. A notification is information about important events which the provider is required by law to tell us about. We also reviewed any other information that had been shared with us by the local authority and quality monitoring team.

Bishops Croft was inspected in February 2016 where we identified four breaches of regulation.The provider sent us an action plan stating that these breaches would be addressed by June 2016. The service did not have a registered manager in post. We found that although some improvements had been made, areas were found where the provider had not met regulation.

We spoke with people who lived at Bishops Croft and spoke with the acting, deputy and operations manager and support workers.

People at Bishops Croft told us what it was like to live there. We also carried out observations in communal areas and throughout the home to see how people were supported throughout the day and during their meals. We looked at care records for three people. This is when we look at care documentation for people to get a picture of their care needs and how these are met. We also looked at documentation in a further care plan to follow up on specific health conditions and areas of care for the person, including risk assessments.

Medicine Administration Records (MAR) charts and medicine storage and administration were checked and we read daily records and other information completed by staff. We reviewed three staff files and other records relating to the management of the home, such as complaints and accident / incident recording,

quality assurance and audit documentation.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in February 2016, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of staff available and deployed to cover all shifts, to meet people's needs, preferences and to meet the funded hours allocated for people.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by June 2016. At this inspection we found improvements had been made and the provider was now meeting this regulation. However, information regarding one to one funded hours and the recording of how this was provided, needed to be embedded into practice to ensure this was consistently clear for each person. We found some further areas which needed to improve to ensure that the service was safe which were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at Bishops Croft told us they felt safe and that staff were there to help them when they needed. Despite this positive feedback we found some areas in relation to safety that needed to be improved. Recruitment had been on-going since the previous inspection. The acting manager told us that staff turnover had been high but this was improving, staffing levels had recently been reduced as there had been a change to the number of people living at Bishops Croft. Levels were assessed taking into consideration the number of people living at the home and their care needs, including any one to one funded hours which needed to be met. We looked at staffing levels and how these were managed to ensure that people with funded one to one hours had this provided. The acting manager told us there was a form used by staff to record how they had spent one to one time with people. Although staff and people living at Bishops Croft told us how one to one support was provided, this had not always been recorded to evidence that everyone's funded hours had been met. Although improvements had taken place changes needed to be further embedded into practice to demonstrate how the provider was consistently meeting this obligation for each person with funded hours.

Night staffing levels were currently one member of staff. We looked at risks identified for people and personal emergency evacuation procedures (PEEPS). We found these identified peoples individual support needs, which included that people would 'need to be supported at meeting point in case they become upset,' 'may become panicked in the event of a fire' ' will need support, and may refuse to leave, needs to be encouraged and reassured.' Some people were considered vulnerable if accessing the community unsupported, therefore once evacuated from the building would require continued support. One PEEP included that the person should 'report to the member of staff if evacuation required at night and stay by their side.' If evacuation was required at night, it was not clear how one staff member would manage an emergency evacuation on their own, whilst ensuring safe evacuation was started and support provided for peoples identified needs. Fire safety checks and fire alarm drills had taken place. It was noted that on more than one occasion people living at Bishops Croft had been reluctant to leave the building when the fire alarm rang. Staff told us this was because people knew it was not a real fire. People had been told about evacuation at 'Your Voice' meetings and were able to tell us the importance of leaving the building if the alarm rang. However, people had been identified as at risk of becoming anxious, upset or worried by

changes to routine. Therefore evacuation procedures needed to be clear to ensure staff could carry this out safely and effectively and ensure people's safety at all times.

The acting manager confirmed that one staff member had support needs which meant there were areas and responsibilities within their role for which they would require support. No risk assessment or guidance was recorded to show how reasonable adjustments would be made to ensure this was possible. This support need had not been identified in the recruitment process and there was no risk assessment in place to determine whether this had an impact on their ability to work in the home or how this was being managed. As this person worked unsupervised it was not apparent how this had been assessed as safe and appropriate. We also identified that conflict of interest procedures were not fully put into practice or explored relating to staff. Risk assessments had not been completed and no management plans were in place to identify how this would be managed. The new operations manager visited the service during the inspection; they informed us they had been unaware of this and that both these issues would be reviewed.

Risk assessments were in place for a number of areas, including road safety, going out, attending activities, fire safety, medicines and challenging behaviours. However, individual risks to people due to their health, support and care needs were not always identified fully or plans managed to ensure people remained safe. We found that risk assessments had been completed which identified a person was at risk of anxiety and depression. Staff told us that when this person's mood deteriorated they were reluctant to engage with staff. This could lead to their personal rooms becoming untidy and cluttered as they had a tendency to hoard items. Although some information was recorded which identified this risk, no plan of care was in place to show how this was managed. Records included that interventions by staff would be required to keep the environment to a safe level of cleanliness. However, we saw that this had not taken place. Staff told us that this person had not been at the service for approximately two weeks. Their personal living area had not been maintained to ensure this would be a safe environment for the person to live in if they returned to the home and did not demonstrate that appropriate systems or actions had been followed. There were two prescribed creams in the room which were out of date and a large amount of toiletries and clothing.

Care and treatment must be provided in a safe way, by doing all that is practicable to mitigate risk. The above issues meant that people's safety and welfare had not been adequately maintained at all times. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records showed checks were undertaken before staff began work. We looked at three staff recruitment files to see how the provider ensured safe recruitment processes were followed. The acting manager told us that a recent audit had been carried out on the staff files. Staff records included a completed application form with employment history, references and the completion of a Disclosure and Barring Service (DBS) check. A DBS check is completed before staff began work to help employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms, confirmation of identity and references were also completed. When there were queries raised about one staff member's reference, records showed that this had been considered and a decision was taken that the issues raised were not applicable to the new employment and should not affect their decision to appoint the person. However, a second staff member's employment history was not stated and there were no interview notes, so it was not evident that this had been explored with them before reaching a decision to appoint them. As this person had been employed some time ago the acting manager told us it had not been possible to locate the interview records or follow up on this, although the gaps had been identified during the recent audit.

Risks in relation to people's nutrition were reviewed and assessed. Safe systems in relation to nutrition were implemented to ensure that each person's daily calorie requirements were met and reviewed. This is

particularly pertinent due to the serious health implications which can arise if nutrition is not managed and planned effectively for people with PWS. One person had a diagnosed health condition and although there was a risk assessment in place regarding this, there was no care plan to inform staff how this was to be managed. This health need was relevant in relation to medication and nutrition but this information had not been included in these areas to ensure staff had access to this information. The acting manager told us this would be implemented immediately to ensure information corresponded.

There was a system in place to record and report accidents and incidents; however this needed to be more robust. We saw that when incidents occurred a form was completed to record the events. However information regarding follow up actions and any learning taken forward were not always recorded. Staff told us information was completed on the form then the manager put this onto the computer system and the information was sent to head office. This meant that outcomes were not always clear for staff and any actions taken forward were not identified on incident forms. Forms had not always been signed to show whether there had been management review of the form. An incident log was used to identify any trends or themes developing. However we found one incident which had not been included on the log. The acting manager was not sure why this had not been added to the log. Systems to monitor and review accidents and incidents needed to be improved to ensure that all actions taken after the incident were clear and any learning identified taken forward.

The deputy manager was aware of the reporting procedure for any safeguarding concerns. Staff demonstrated a good knowledge around how to recognise and report safeguarding concerns and told us they could also contact the provider if they had concerns. Staff told us that they had training around safeguarding and information was available around the service to inform people of actions to take if they suspected abuse.

Information was in place to show that systems and equipment used within the home were monitored and serviced as required. This included water checks and legionella, gas, fire and personal appliance testing (PAT) for all electrical items. Contingency plans were in place, contact details were in place for all more serious issues and there was also emergency contact information for staff at all times if needed.

Procedures were in place to support safe medicine systems. There was a medicines room where medicines were stored securely. We observed medicines being given and saw that this was done following best practice procedures. Medicine protocols included guidance for 'as required' or PRN medicines. PRN medicines were prescribed by a person's GP to be taken as and when needed. For example pain relieving medicines. PRN guidance identified what the medicine was, why it was prescribed and when and how it should be given. Staff followed clear processes and ensured that PRN medicines were considered, specifically if prescribed for pain relief. One person came to the office to speak to staff during the inspection. They told staff they had a headache. Staff went with the person to give them a pain relief tablet which was prescribed for them to take as and when required.

To ensure peoples' safety in relation to PWS, prescribed toothpaste, creams and other consumable medicines were stored in the medicines room. Medicines were labelled, dated on opening and stored tidily. Medicine fridge and medicine room temperatures were monitored regularly to ensure they remained within safe levels for storage. People who were able to self-administer some or all of their medicines had regular reviews carried out to ensure this was safe to continue. However we did find two pots of cream in a person's room, one which was out of date and another with a faded label so it was not possible to determine how old it was. These were removed during the inspection. There were protocols in place for any homely remedies people took. When people went to stay with family this was clearly recorded within the MAR charts with a list of medicines that people had taken home with them.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in February 2016, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because Deprivation of Liberty Safeguards (DoLS) assessments had not been completed appropriately to prevent unlawful restriction on people and a lack of adequate training and understanding around DoLS.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by May 2016. At this inspection we found that although improvements had taken place this needed to be further embedded into practice to ensure information and decisions were clearly recorded within peoples care documentation.

DoLS applications had been made, best interest meetings had taken place and records were in place to show when applications had been authorised or refused. However, when authorisations had been refused or urgent authorisations had run out, this had not led to renewed applications or care plans being updated for two people to identify how people's safety was being managed effectively. One had an application for DoLS refused in June 2016. Although the DoLS list updated by staff said there was no DoLS in place. No information was in place to show how restrictions for this person were being managed differently to those people who had DoLS authorisations in place. For example, in relation to access to food and kitchen access, finances and medication. One person's urgent DoLS had run out and the acting manager told us they were not aware of this; however the risk in relation to this was low as this person was not currently at the service. We were informed immediately after the inspection that DoLS applications had been re submitted for the person who did not have one in place and that this was in now in progress. Although the acting manager responded immediately to the areas identified and the impact was low, DoLS management overall needed to become fully embedded into practice and managed effectively to ensure that restrictions in relation to specific areas of people's care were accurate and robust. We recommend the provider seeks appropriate guidance in relation to DoLS and MCA.

Staff training records were available and these showed an on-going training programme which was used by the provider. Training included specific PWS training and managing behaviours that may challenge. The training record identified the date training was assigned to the staff member and when it was completed. When training was out of date or not completed this highlighted as red to alert that this had not been completed. Training records were reviewed by the organisation to identify the percentage completed. If this fell below a designated percentage this was raised as a query with the person managing the service to address. Staff told us they felt the training was helpful but that there had been some issues accessing the computer training system for some staff to enable them to complete the training at home. Staff were encouraged to do further training, for example, one staff member told us they were being considered to do a team leader National Vocational Qualification (NVQ) training to support their role. Staff knew people well and were able to tell us about their specific support needs and what situations may trigger increased anxiety levels for people and how to manage this when it occurred. However, records identified that some areas of training needed to be addressed. One staff member who worked alone at night had a number of areas of training which had not been completed. The acting manager told us this was due to support needs; however

there was no system or plan in place to show how this was being addressed. Staff who work unsupervised may not have the appropriate skills and knowledge to ensure peoples care and support needs were met at all times if required training has not been completed.

New staff completed a period of induction, this included completion of the induction workbook and training. New staff also shadowed other staff until they felt confident working on their own. The acting manager had carried out supervision for staff and we were told that this was an on-going programme and was aimed to take place every six weeks. The acting manager confirmed that this had fallen a bit behind and we saw that although most staff had received supervision in January and some had received a further supervision in March 2017, two staff had not received supervision since January 2017. Staff told us they used supervision as an opportunity to discuss any work or personal issues. And if they had any concerns they would be happy to speak to the acting manager or someone from the organisation operations team at any time.

We spoke with four people at lunchtime. Everyone was sat at the dining table, they told us they liked the food and they had a choice in what they ate. The meal presented looked appetising. Three people had a stir fry and one person had fish cakes. People told us they were happy with the meal provided. A recording system to inform staff of people's meal requirements had been implemented. Safe systems in relation to nutrition are particularly pertinent due to the serious health implications which can arise if nutrition is not managed and planned effectively for people with PWS. Since the last inspection work was in progress to change nutrition care plans to ensure they were person centred and this was on-going. The acting manager had looked at ways of ensuring people's weights were monitored and changes made to people's nutrition as required, to keep them safe and healthy. Further changes were in progress and changes to nutrition were being reviewed. This included how to increase or decrease calories if needed and how this corresponded to people's regular weight reviews and associated health needs, meal recipes and the calorie counting for all ingredients. One person told us that a Panini maker had been bought and they were looking forward to trying this. Staff told us this had been in response to discussions at resident meetings and an attempt to find an alternative to bread for people. People's weights had been monitored weekly. Regular monitoring and documentation identified changes made to people's nutrition to keep them safe and healthy.

People told us they had a choice in how they spent their time. However staff explained that although there was choice, days were fairly structured as people liked routine and liked to know what was going to happen. People's anxieties could be increased when there was undue change to routine. People told us that they could get up and go to bed when they chose and that they knew what time they would be having meals and drinks. We saw that one person had been due to go out on the day of the inspection, however they had chosen not to attend and their choice had been respected.

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs and health related appointments.

Requires Improvement

Is the service caring?

Our findings

People said that they liked the staff. One told us, "Staff take me out for a walk, and I listen to music." Another told us, "If I need them they are here, or you go to the office and speak to them." We observed people going up to staff and stopping to talk to them and it was clear that people knew staff and were happy to talk to them. Staff responded promptly to people's requests and queries and there was an open and light hearted rapport between staff and people.

Despite this positive feedback, on one occasion we observed that when a person's anxiety levels increased and they became frustrated or anxious, they raised their voice to staff. The staff member responding to the person's anxiety also spoke louder in response. Although this was not shouting, it did not facilitate a calming of the situation and the conversation continued at this level for a few minutes. This conversation was in the kitchen and could be heard in the main office on the top floor of the building. Staff also needed to be aware of confidential information in relation to peoples care needs when making telephone calls. Staff were seen to walk around whilst on the portable telephone and this meant conversations could be overheard by anyone in the vicinity. When a person's behaviours had escalated leading to them causing damage and disarray in their living area, this had not been addressed in a timely manner. This person was currently away from the home and had been for approximately two weeks. Staff told us the area had been tidied previously but the person had then 'trashed it again 'before they went. A management plan was not in place to show how this behaviour was being managed or that people's privacy and confidentiality was maintained at all times. This was an area that needed to be improved.

Other interactions between staff and people were seen to be calm and relaxed. Staff knew people well and chatted to them about their plans for the day and what they wanted to do. Staff told us they respected people's privacy. If appropriate, people had access to keys to lock their rooms and had signed an agreement regarding this. One person had an alarmed bedroom door to alert staff if anyone opened the door to go in or out of the room. This had been a decision made with the person.

People were supported by named keyworkers. Although they told us the keyworker sometimes changed due to staff leaving or if the person had asked for a different keyworker. Staff were aware there were responsibilities if you were a keyworker, telling us, "You need to be clear about their abilities and areas they need support with, we also keep families up to date with any changes."

Care files included pertinent information about people in relation to how they may behave if they become anxious or upset. On person's file included information for staff around understanding their behaviours. 'No matter how abusive I am, no one is more scared than I am and this is why I am demonstrating such behaviours.' This showed consideration and understanding of the person's needs and an explanation of why their behaviours may escalate.

Equality and diversity were supported. Care plans were in place to support and safeguard people when they had friendships or relationships with others. We saw that on occasions people visited other services run by the organisation to see friends and meet with other people using the services. Systems to support and

encourage people to be as independent as possible were seen. Some people needed to be supported when they went out due to their PWS or behaviours that may challenge. One person independently attended their activity or work placement. An agreement was in place with the person that they informed staff when they were leaving the building, telephoned when they arrived and let staff know they were on their way back. Staff told us this was working well and the person appreciated the level of independence this gave them. We saw that this person approached staff when they were ready to go out and told them where they were going and staff checked that they had everything they needed.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in February 2016, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of person centred activities designed to meet people's individual preferences. An action plan was submitted by the provider that detailed how they would meet the legal requirements by June 2016. At this inspection we found improvements had been made and the provider was now meeting this regulation, however some areas needed time to become fully embedded into practice.

Peoples care plans had been improved and work had taken place to ensure they were more person centred. We found that although improvements had been made, information had not always been reviewed and updated to ensure it was relevant and up to date. Care files identified goals for people which they had set themselves. These included peoples wish to be more independent. Information around people's goals was not updated to show when goals had been met or changed. This meant that peoples social and support needs may not be current and staff may not be aware of people's current goals and how to support these effectively.

Peoples care records included what was a 'good day' and what was a 'bad day' for them and what this might look like. For example a good day might be when they feel happy and supported and a bad day might be when they cannot do the things they would like to do. Information regarding people's routines and what was important to them was completed. This included, 'staff respecting their privacy' or 'supporting them with aspects of their personal care or health needs'. When people had identified health or support needs we saw that they received support regarding these. One person had received a visit from a health professional in relation to their specific health needs. Strategies were put in place in October 2016 however it had not been documented to show if these had been reviewed again or updated. This meant that peoples changing support needs and strategies in place may not be current as information had not been updated. This could impact on how people receive care.
Although care files were generally improved to ensure they were more person centred, changes to needs, goals and care were not easy to follow. As people were identified as becoming anxious due to change and needing to know what was happening and when, the support plan could not easily be navigated by a new staff member and it would be very easy to give information that is not correct. This needed to be improved to ensure information was clear to inform staff of people's specific needs.

People told us they attended a number of activities and attended work placements. There were designated activity co-ordinators. Activities included some in house activities which were provided within the wooden chalet in the garden or a number of external activities which people attended supported by staff. People had a weekly plan which included their planned activities for the upcoming week. Everyone had a designated 'house day' which was their day to do washing and cleaning. Further on going improvements were taking place with a meeting scheduled to discuss activities and how these would be taken forward to further improve and ensure activities continued to be person centred and based on people's preferences. Activities were varied and people said they had enough to do during the day and that there were enough staff to support them to do the things they liked doing. These included swimming, gym, cinema, exercise and dance

classes. People were supported to go shopping and attend church services if they wished. One person said they could not go to the gym anymore due to their health but that they now go for a walk instead.' People visited other services belonging to the organisation to see friends and attend activities with others. Peoples work placements were varied. One person told us they worked with horses. Another told us they were waiting for checks to go through before they began their placement. On the day of the inspection most people went out in the morning and returned for lunch, then went to the sauna in the afternoon. One person had declined to attend the morning day services and had spent the day at Bishops Croft. This person told us they did not want to go out that day. When people had continually refused to attend activities this was included in their care records. Staff were monitoring people's engagement in activities to try to prevent them from becoming socially isolated. The acting manager told us they would continue to offer a range of activities to try and encourage this person to attend more frequently.

People were involved in gardening and there were a number of cuttings by the front door for planting in the garden. We were told people grew tomatoes and vegetables and were in the process of planning the building of butterfly and bug houses. People told us that in the communal areas the television had to be turned off at 11pm through the week and 12 at the weekend. These were house rules agreed by everyone.

The service user guide and activities information were displayed on the noticeboard to let people know what was available. Alongside easy read information relating to DoLS and safeguarding, the quarterly newsletter was displayed; this was edited by one of the people living at Bishops Croft. Staff told us this person loved anything to do with technology and IT and they were currently trialling a PWS related game for a university.

A complaints policy was available. Information regarding how to make a complaint was displayed. People said they would speak to any of the staff or the acting manager if they had any concerns. The acting manager told us there were no current on-going complaints being investigated by the organisation. Minor issues were addressed and responded to when they were raised. Letters from people living at Bishops Croft raising concerns had been responded to by the acting manager and copies of these letters had been logged. Complaints if received would be sent to the head office to ensure they had a record of all issues raised in the home.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in February 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of accessible and up to date records and recorded response to feedback from people. Effective audits and service improvement plans were not in place to identify shortfalls and make necessary improvements.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by June 2016. At this inspection we found that although some areas had been improved further improvements were needed to ensure the changes were maintained and reviewed and fully embedded into practice.

There was no registered manager at Bishops Croft. The previous registered manager had not worked at the home for over 15 months but had not been de-registered with CQC until April 2017. There had been acting and deputy managers covering the day to day running of the service since the last inspection in February 2016. The current acting manager had not registered with CQC and had decided not to take up this position.

There had been a high level of staff turnover within the home since the last inspection, including changes to leadership, senior and support staff. We were told there had been low morale and issues within the home regarding staff support and teamwork. Some staff had chosen to leave and two new staff had more recently been employed which was improving things. Staff were now supporting each other better, but there was still some work needed to ensure everyone employed was working together to provide seamless care and support for people. The acting manager told us that some of the challenges related to staff who had worked for the previous provider and had been reluctant to accept change. There had also been inconsistent support for the acting manager from the organisation. Although this had improved the acting manager had decided not to take up this position. Staff told us they felt things were better and that they could see the on-going improvements.

The provider had not ensured that there was consistent strong leadership at Bishops Croft. Previously staff who had been left in charge did not always have the skills and experience to lead effectively and required a high level of support to ensure that the home was well led at all times. The provider had not ensured this was provided and senior staff felt that they were 'left to get on with it'. Changes had taken place recently and staff now felt that improvements had been made and were on-going; however there was no registered manager in post to facilitate this continued improvement. Recent changes to the organisations structure had meant that senior positions within the organisation had changed. We met the operations director during the inspection and were told about regional and area support that would be in place for services. However, all operations staff were covering a large area and a high number of services. Due to the lack of registered manager and the need for day to day strong leadership at Bishops Croft the provider needed to ensure that improvements were implemented promptly, maintained and monitored as part of a robust quality assurance and improvement plan.

Some areas of documentation needed to be further improved to ensure information was up to date. People had identified short and long term goals. Documentation included who was involved in helping people

reach these goals. Despite goals being in place, further information had not been completed to show if people's goals had been achieved or the timescale for reviewing these. A goal identified by one person included staff supporting them to be more independent and travel to a nearby town. This goal included information that staff would go with them once, shadow three times and then assess if an agreement could be implemented for the person to do this unsupervised. A further goal was then documented regarding shopping, however no information is recorded regarding the original goal to explain if this was achieved or changed or why this had not continued. A new agreement was in place regarding shopping but this had not been reviewed or evaluated. This meant information was confusing and did not explain if goals had been achieved or why they had discontinued. This needed to be improved to ensure all areas of documentation were updated and reviewed.

Regular service user meetings had taken place each month and these had been minuted. At the meeting on 11 January 2017 one person had requested a change to their keyworker which had been implemented. One person had expressed concern that discussions regarding all people living at Bishops croft were taking place when everyone was not present. They had asked that this 'Please stop as any decisions that affect everyone need to take place in the house or day services when everyone is present'. The minutes included that this was to be discussed at the staff meeting. However, a staff meeting took place the following day and the minutes did not show that this had been shared with staff or discussed. The acting manager told us the information had been shared verbally but not documented; staff confirmed they were aware of this information.

Questionnaires had been used to gain feedback from people regarding the service. Recently sent out questionnaires were currently being received back, we were told that the collated feedback was to be sent to the organisation for review and analysis. We looked at the previous feedback received and were told that the responses had not been sent to the organisation and no analysis was available. There were responses analysed from June 2015. A new structure was now in place which included a quality team to complete audits, reviews and respond to any actions identified. Audits completed by the manager of the service were then sent via the computer programme to the organisation for overview. This enabled them to have clearer oversight of the home. Any actions would be identified and followed up on to ensure they were addressed in a timely manner. Audits included medicines, monthly safety checks, quarterly site governance self-assessments and quality audits completed by quality leads. The provider had visited to carry out provider audits and there was evidence of input at the home since the last inspection. We discussed with the acting manager the importance that the provider maintained this level of oversight to ensure the large number of improvements made are continually improved, reviewed and sustained. The acting manager was aware that auditing and systems were an on-going plan which may need to be amended to ensure that all areas are incorporated and to maintain checks to the appropriate levels and may take time to become fully embedded into practice.

Although some improvements were in place these needed to be reviewed to ensure that the service was continually well led at all times. We recommend the provider seeks appropriate guidance to ensure this is addressed.

Staff meetings held regularly and included set agenda topics and additional items discussed. This showed that a wide range of topics were included within staff meetings and staff had a say on matters relating to the way the home was run. Staff meetings were minuted and staff invited to share ideas and give feedback. Staff also completed an employee engagement survey. This gave staff the opportunity to feedback anonymously if they wished and included whether staff enjoyed their work, felt encouraged to suggest new ideas and were able to manage workload. Staff were aware of the regulatory requirements and had been looking at the CQC methodology and how this could be incorporated into every day processes.

The acting manager demonstrated a good understanding around what needed to be reported and required notifications had been completed in a timely manner. They had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. The acting manager confirmed a procedure was in place to respond appropriately to notifiable safety incidents that may occur in 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way, by doing all that is practicable to mitigate risk. The above issues meant that people's safety and welfare had not been adequately maintained at all times. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 12(1)(2)(a)(b)(c)(d)