

Parkcare Homes (No.2) Limited

Mather Fold House

Inspection report

Hoghton Lane
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Preston
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Tel: 01772311371

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This unannounced inspection took place on 06 and 07 July 2017.

Mather Fold House is a six bed residential service in Higher Walton Lancashire. This specialist autism service is for male and female adults aged 18 years and over, but can also accommodate people who are 17 years and are going through transition from children's to adult services. Located in the village of Higher Walton which is positioned between Blackburn and Preston, the service is close to the town centre and within walking distance of local amenities. There were three people who lived at the service at the time of our inspection.

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

This inspection was the first inspection since the service was registered with the Commission on 20 November 2015.

During this inspection we found the service to be in breach of one regulation under the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. The breach was in respect of Regulation 13, safeguarding service users from abuse and improper treatment. This included shortfalls in the systems and arrangements for protecting people from abuse and improper treatment associated with use of physical restraint. We also made a recommendation in relation to staff training, supervision and development. You can see what action we told the registered provider to take at the back of the full version of the report.

There were policies and procedures on how the service protected people against bullying, harassment, avoidable harm and abuse. Majority of the staff had received introductory training in safeguarding adults. We found evidence to demonstrate that physical restraint had been used disproportionately in response to risks of harm posed to one person. Staff had not always explored other less restrictive ways of reducing risks before using physical restraint. This had been noted by the registered manager and processes for learning from this had been implemented but needed to be imbedded.

Staff had sought advice from other health and social care professionals where necessary. There were risk assessments which had been undertaken. Plans to minimise or remove risks had been drawn up and reviewed in line with the organisation's policy. These were robust and covered specific risks around people's care and specific activities they undertook in a person centred manner.

People were protected against the risk of fire. Building fire risk assessments were in place including personal emergency evacuation plans (PEEP'S).

There was a medicines policy in place and staff had been trained to safely support people with their

medicines.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. These had been followed to ensure staff were recruited safely for the protection and wellbeing of people who used the service. Records we saw and conversations with staff showed the service had adequate care staff to ensure that people's needs were sufficiently met.

We found care planning was done in line with the Mental Capacity Act, 2005. Staff showed awareness of the Mental Capacity Act, 2005 and how to support people who lacked capacity to make particular decisions. They had received mental capacity training.

People who used the service had limited ability to provide us with feedback on the service due to their needs. Feedback from relatives about care staff was positive.

People using the service had access to healthcare professionals as required to meet their needs. Staff had received some training deemed necessary for their role. However there were shortfalls in induction, supervision and some of the training deemed necessary for the role. Record keeping around training and development needed some improvement to ensure the service identified training needs and shortfalls effectively. Staff competences were checked regularly in various areas such as medicine administration. They had also been provided with annual appraisals.

We found that people's care needs were discussed with care commissioners before they started using the service to ensure the service was able to meet their assessed needs. Care plans showed how people and their relatives were involved in discussion around their care. People were encouraged to share their opinions on the quality of care and service being provided. People's nutritional needs were met. Where people's health and well-being were at risk, relevant health care advice had been sought so that people received the treatment and support they needed. There were a variety of activities provided to keep people occupied.

We received mixed feedback from staff regarding management of the service and shared the feedback with the registered manager.

There were established management systems at the service. There had previously been instability in leadership however this had improved. The Regional manager had been involved in the day to day management of quality at the service. The registered manager had provided oversight on duties they delegated to other staff.

Quality assurance systems were in place and various areas of people's care been audited regularly to identify areas that needed improvement. We found audits had been undertaken of care records, and medicine administration records, finances, health and safety and the overall quality of the care provided by the service. There were areas of improvement in respect of completion of action plans for areas identified to require improvement by the audit processes. There was a business contingency plan to demonstrate how the provider had planned for unexpected eventualities which may have an impact on the delivery of regulated activities.

Feedback from relatives showed they felt their relatives received a good service and they spoke highly of the staff. Relatives told us the staff were kind, caring and respectful and were considerate in their approach to dealing with some challenging situations. Professionals we spoke to confirmed this.

We found the service had a policy on how people could raise complaints about their care and treatment. Relatives told us they could raise concerns and felt listened to.

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 

This service was not consistently safe.

People and their relatives told us they felt safe. Feedback was positive.

Risks to the health, safety and well-being of people who used the service were assessed and plans to minimise the risk had been put in place.

The use of physical restraint had not always been considered as the last resort and had not always been used proportionate to the risks posed.

People's medicines had been safely managed. Staff had been trained and competence tested for safe administration of medicines.

Staff had been safely recruited and disciplinary measures were in place.

Is the service effective?

Requires Improvement 

This service was not consistently effective.

The rights of people who did not have capacity to consent to their care were protected in line with the MCA principles.

Staff had not always received training, induction and supervision to ensure they had the necessary skills and knowledge to carry out their roles safely.

People's health needs were met and specialist professionals were involved appropriately.

Is the service caring?

Good 

The service was caring.

Relatives spoke highly of care staff and felt their family members were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.

Staff knew people and spoke respectfully of the people they supported.

Is the service responsive?

Good ●

The service was responsive.

People had well written plans of care which included essential details about their needs and outcomes they wanted to achieve.

The provider had gained the views of people who used the service and their representatives. Care was reviewed regularly.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their care and treatment. Complaints had been dealt with in line with policies and procedures.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

People felt the service was well managed.

There were adequate governance systems within the service. Management oversight had been provided to care staff and the overall running of the service.

Systems for assessing and monitoring the quality of the service and for seeking people's views and opinions about the running of the service were implemented to improve the care and treatment people received. However systems for monitoring to ensure staff induction, training and supervision were not robust. Systems for learning from incidents had not been fully monitored.

Mather Fold House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 05 and 06 July 2017 and was unannounced.

The inspection team consisted of one adult social care inspector who is the lead inspector for the service.

Before the inspection, we had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and when we made the judgements in this report.

Before the inspection we gained feedback from health and social care professionals who worked together with the service. We also reviewed the information we held about the service and the provider. This included safeguarding alerts and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law.

During the inspection, we used a number of different methods to help us understand the experiences of people who used the service. We reviewed records of care and management systems used by the service for care delivery. We observed the environment and staff supporting people, spoke to one person who was able to share with us their experiences of living at Mather Fold House. We spoke with one relative face to face and two relatives by telephone. We also spoke with the operations manager of the service, the registered manager, the positive behaviour practitioner, three professionals who had visited the service, and five care staff. It was not possible to gather the views of the other two people who lived in the service due to their communication needs. However their relatives were able to share their views with us.

We looked at care records of the three people of which two records were pathway tracked.

Pathway tracking is where we look in detail at how people's needs are assessed and care planned whilst they use the service. We also looked at a variety of records relating to management of the service. This included staff duty rosters, five recruitment files, the accident and incident records, policies and procedures, service certificates, minutes of staff meetings, reports from safeguarding professionals and also quality assurance reports, audits, action plans, and medicine records.

Is the service safe?

Our findings

We asked relatives of people who used the service whether they felt safe receiving care from the service. All people we spoke with told us they felt safe. Examples of comments included, "Yes he is safe and much better than where he was" and "I have no concerns with safety and the care workers."

Staff we spoke with were aware of the signs of abuse and discussed the appropriate actions they would take if abuse was suspected. Staff told us they had no concerns about the care people received and were aware of the whistleblowing policy (reporting bad practice). They told us they would feel confident reporting any concerns to the registered manager. Comments included, "I have no concerns about the care or the service" and, "I know if I raise something with the manager it would be looked at.", "There is enough staff here and the staffing situation has been improving over the last few months."

Feedback from professionals was equally positive comments included; [Registered manager] and the team at Mather Fold have made huge efforts to ensure safe and comfortable transfer of [name] to their care. I have no hesitation in recommending this service and I just wish they had more vacancies for some of our other clients."

Before the inspection we had received concerns from the local safeguarding team and from care staff regarding safety arrangements at the service. This included concerns around a lack of staff training, staff shortages, poor care practices and also lack of protective equipment to protect staff. During this inspection we looked to see how the provider had responded to the concerns raised. Recommendations that had been made by safeguarding professionals had been followed to ensure people received safe care and treatment. The majority of the care practices had improved and personal protection equipment had been purchased to protect staff during personal care interventions.

We saw records of safeguarding enquiries and alerts that had been completed. Evidence we saw demonstrated that care staff were able to report concerns if they suspected people were at risk of exploitation or harm. We looked at how the procedures and processes to protect people using the service from being abused by staff or other people they may have contact with when using the service. We found the service provided care and treatment to people who could display behaviours that can challenge others. Records we saw and conversations with staff and relatives demonstrated that there were instances where it had been deemed necessary for staff to use physical restraint and medicines to calm individuals where their behaviour had posed a risk to themselves, others and/or property. Relevant authorisations had been obtained to ensure staff acted lawfully and records had been kept when it had been necessary to use physical restraint.

We found an analysis had been carried out on the number of incidents and instances of physical restraint. We also noted that over the last two months before the inspection there had been a significant reduction in the use of restraint and sedating medicines had not been used for two months. There was a positive behaviour practitioner who worked with the service to support them around managing the needs of people whose behaviours might challenge others. A positive behaviour practitioner is trained in specialist

approaches, such as applied behavioural analysis and positive behaviour support, which are intended to enhance the quality of life and opportunities by establishing consistent supported approaches that complements the individual and reduces the potential for challenging behaviour.

While in the majority of the cases we looked at we found staff had acted appropriately in relation to the use of physical restraint, we also found some concerns demonstrating that procedures had not always been followed. Incident reports written by staff showed instances where the use of physical restraint had not always been used proportionate to the risk a person was likely to cause to themselves, others or property. Records also showed restraint had been used as the first option; there was no documented evidence to demonstrate what other actions staff had attempted to de-escalate the situation before restraining a person. We looked at the records completed after the incidents also called de-brief. The records showed a lack of scrutiny and a lack of questioning the culture between the staff team. Evidence showed an inconsistent response to incidents among the staff team. Not all staff who worked in the service had been trained in the safe use of restraint and safeguarding adults' awareness.

We spoke to the registered manager regarding these concerns. They acknowledged our findings and informed us that they had recently identified similar trends and concerns that restraint had been used disproportionately by some of the staff team. They added that they had identified which staff required further support and development in this area. They also informed us that safeguarding training had been booked for September 2017. Soon after the inspection we reported our concerns to the local safeguarding team.

There were shortfalls in the systems and processes for preventing abuse of service users. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at information that we had received from people regarding care staff who had been alleged to have acted unprofessionally. We found disciplinary measures had been instigated when there had been a complaint or concern about staff conduct.

We looked at how the service protected people against risks of receiving care and treatment. We looked at three people's care documents. There were risk assessments in people's care files which included risks of choking, falls, medicine misuse, and personal care and risk assessments associated with specific activities that people undertook such as swimming and outdoor walks.

Care files we checked demonstrated that people's risks had been assessed, documented and reviewed regularly when there was a change. Risks had been clearly identified and staff had been provided detailed guidance on how they could ensure risks to people were reduced. For example in one person's records staff had been clearly guided to take extra caution when supporting the person to reduce the risk of personal harm. In another example the staff had identified the risk of people pulling fittings from the walls such as electrical fittings and plumbing fittings. They had provided specially adapted fittings and decorations to minimise the risks. This meant that the service had identified people's risks and put measures in place to minimise them.

We looked at the risk assessments in place concerning fire safety and how people would be supported in the event of an emergency. We saw the service had contingency plans in place and personal emergency evacuation plans for people who lived there should people ever need to be moved to a safer area in the event of an emergency. These documents gave guidance to care staff on how people needed to be supported in an emergency, including the closest fire escape to their room. There was an overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures

and fire exits were kept clear. Records showed that staff had been involved in fire safety practice drills.

Maintenance records showed safety checks and servicing in the home including the emergency equipment, water temperatures, fire alarm, call bells and electrical systems testing. Maintenance checks had been done regularly and records had been kept. We could see that recommendations made by the fire safety inspector had been followed. Faults and repairs had been highlighted and addressed. These measures helped to make sure people were cared for in a safe and well maintained environment.

We found there were plans in place to respond to any emergencies that might arise and these were understood by staff. The provider had devised a continuity plan. This set out emergency plans for the continuity of the service in the event of adverse events such as loss of power or severe weather.

We looked at the arrangements in place for managing people's medicines. Relatives of people who lived at Mather Fold House were satisfied with the way their relatives' medicines were managed. Staff designated to administer medicines had completed a safe handling of medicines course and undertook competency tests to ensure they were competent at this task. Staff had access to a set of policies and procedures which were readily available for reference. We saw staff administered medicines safely, by checking each person's medicines with their individual records before administering them. This ensured the right person got the right medicine.

As part of the inspection we checked the procedures and records for the storage, receipt, administration and disposal of medicines. We noted the medicines administration records for medicines were well presented and organised. Medicines audits (checks) were in place and we saw daily and monthly checks carried out by the senior staff and management. Concerns and errors had been identified during the audits and actions had been taken to ensure people continued to receive their medicines safely. Where errors have been found, staff had been asked to undertake further training in medicines management before they could be allowed to administer medicines unsupervised.

There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard or secure safe, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the home's policy.

We found there were suitable arrangements for the management of creams such as topical creams. Cream charts and body maps had been introduced which guided care staff on where to apply the creams. In majority of the cases staff had recorded and signed when they had applied the creams.

We discussed the importance of ensuring that documented evidence of authorisations is kept, where it had been necessary to administer medicines covertly. The registered manager took immediate action to seek written permissions from the GP.

We looked at how the provider managed staffing levels and the deployment of staff. Before this inspection we had received concerns regarding the staffing levels. On the days of the inspection there was adequate staff to meet people's needs. We requested a month's staffing rotas including the week of the inspection. We found the rotas indicated there were sufficient staff available for the three people who lived at the home. The registered manager was on duty five days a week to oversee care and senior staff or the deputy manager was on the day shift across the week and at the weekend to help supervise staff. Care staff we spoke with raised concerns that an increase in the number of people using the service was likely to impact on the service delivered.

We spoke to the registered manager regarding the concerns that had been raised about staffing levels. They informed us that high staff turnover had been an issue at the service, however they had used agency staff to provide cover while they recruited. They showed us evidence that demonstrated they had a number of candidates undergoing the recruitment process and due to commence work. They also informed us of the efforts that they had made to try and attract good staff. For example increasing the wages to make it more competitive. The registered manager also told us that the staffing levels were kept under review and were flexible in response to the needs and requirements of the people who lived at the home. This monitoring of staffing against dependency would be essential when people's needs changed and more staff were needed to meet people's individual needs. We also spoke to staff who confirmed that things were getting better however they had felt more staff were required before more people were admitted into the service. After the inspection the registered manager informed us they had recruited six more staff.

We looked at the records of five staff members employed at the service. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the home. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider had taken appropriate steps to ensure only suitable staff were employed to work in the home.

We looked at how the service minimised the risk of infections and found staff had undertaken training in infection prevention and control and food hygiene. There were policies and procedures for the management of risks associated with infections. Staff wore gloves and disposed used gloves appropriately.

Is the service effective?

Our findings

Relatives of people who lived at Mather Fold House told us they felt the staff were appropriately trained and had the necessary skills and abilities to meet their needs. Comments included; "They listen to what I say and will always check with me if they are unsure", "The staff are good, they have worked wonders with my [relative]", "I think staff are marvellous they are wonderful." And; "They are doing very well with his food and I think his diet had improved." We received positive feedback from the professionals who worked with the service.

Before the inspection we had received concerns regarding shortfalls in staff training and development. We looked at how the provider trained and supported their staff. We reviewed the training records for the whole service and found a number of online training courses had been provided to care staff and face to face training had also been provided in specific areas. However there were some shortfalls in the training that the provider had deemed necessary for the role. Records we were provided with showed that some training was overdue and plans had been put in place and courses had been booked.

There was an induction policy for new employees and arrangements for staff who were new to the care industry to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life.

Staff we spoke with told us that they had started this course. However the staff records demonstrated that staff had not always completed the induction in line with the organisation's policies. Some staff had started the Care Certificate however they had not completed it. The induction records had not been overseen or signed off by the provider to demonstrate that staff had completed the programme.

Staff spoken with told us they were provided with one to one supervisions by the senior staff. However records we saw and conversations with the registered manager showed that senior staff had not received training to provide other staff with supervision. Staff we spoke with raised concerns regarding the quality of the supervision they had received. We saw records of supervision during the inspection. The records showed that supervision had not been provided consistently in line with the organisations' policy. The registered manager informed us that they were aware of the shortfalls in staff training, induction and supervision. They added that there were plans to provide some of the training such as safeguarding, mental capacity and emergency first aid in September 2017 and we saw that training had been booked. They changed the arrangements for supervision immediately to ensure only trained people could provide supervision. The lack of adequate training, induction and supervision meant that staff were not fully supported to have the correct knowledge to provide effective care to people.

During the inspection we found that it was difficult for the registered manager and other senior managers to find records of training to demonstrate what training staff had completed and what training was outstanding. The record keeping was not robust however there was evidence to demonstrate that training and development was provided on an on-going process. The high staff turnover had resulted in some of the training gaps that we identified. The registered manager was aware of these concerns and was taking action to address them.

We recommend the registered manager and the provider to consider recognised best practice in the delivery of staff training and development and update their processes accordingly

Staff spoken with told us meetings were held, so the staff team could get together and discuss any areas of interest in an open forum. This also allowed for any relevant information to be shared with staff. Records seen confirmed meetings had taken place. We saw that during a recent meeting the safeguarding procedures had been discussed. Guidance and changes to practice had also been shared during the meetings.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's records showed that the provider had applied to relevant supervisory authorities for deprivation of liberty authorisations for people. These authorisations had been requested when it had been necessary to restrict people for their own safety and these were as least restrictive as possible. Follow ups had been done to check the progress of the applications that had been submitted to the local authority.

We reviewed how the service gained people's consent to care and treatment in line with the MCA. We looked at people's care records and found mental capacity assessments had been completed to identify whether people could make their own decisions regarding their care and treatment. Best interest's processes had been followed where people had been assessed as lacking mental capacity to make specific decisions. We noted that the provider had ensured people's liberties were promoted as much as possible while minimising the risks to staff and people.

The care staff we spoke with demonstrated an understanding of the legislation as laid down by the Mental Capacity Act (MCA) 2005. Staff spoken with demonstrated a good awareness of the Mental Capacity code of practice, however not all staff had received training in MCA and DoLS.

We looked at how people's nutrition was managed. We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. Systems and processes for monitoring people's nutritional needs were in place. People's records showed people's preferences and risks associated with poor nutrition had been identified and specialist professionals had been involved where appropriate.

We saw evidence of staff following best practice to support people. For example staff explored different way of facilitating communication with one person who had limited verbal communication skills. They were utilising the picture exchange communication system(PECS) to ensure the person can express their needs. The picture exchange communication system, or PECS, allows people with little or no communication abilities to communicate using pictures. People using PECS are taught to approach another person and give them a picture of a desired item in exchange for that item.

People's healthcare needs were considered as part of the care planning process. We noted assessments had

been completed on physical and mental health and there was a detailed section in each person's care plan covering people's medical conditions. This helped staff to recognise any signs of deteriorating health. There were links with the local primary health services and professionals such as local doctors, learning disabilities teams and the local Clinical Commissioning Group.

Is the service caring?

Our findings

We received positive comments about the care staff and the service delivered to people. Comments from relatives included, "The staff are caring and attentive", "I have a good relationship with staff, they listen to what I say" and "I have confidence in the staff they try their best." One relative added that [name removed] is really bubbly and is having a great effect on [relative].

Staff spoken with and the registered manager had a sound knowledge and understanding of the needs of people they cared for. Staff members told us how they enjoyed working at the service. Comments from staff included, "We care for people like they are our family really" and "I like my job and I enjoy supporting people."

We considered how people's dignity was maintained and promoted. We noted people's daily records and care plans had been written in a way that took consideration of their choices and preferences. People had been asked about their likes and dislikes and this had been included in their daily support. Staff we spoke with talked about people in a respectful, confidential and friendly way.

People's privacy was respected. One person chose to spend time alone in their room and this choice was respected by the staff. In another example one person's garden fence had been adapted and raised higher to maintain their personal privacy and dignity. People's bedroom doors were fitted with suitable locks to help promote privacy of personal space. Staff described how they upheld people's privacy, by sensitively supporting people with their personal care needs and maintaining confidentiality of information. We observed staff knocked on bedroom doors before entering and ensured doors were closed when people were receiving personal care.

There was information available about advocacy. Two people who lived at the service had access to advocates who were supporting them regularly. Advocates support people to access information and make informed choices about various areas in their lives. Relatives that we spoke with informed us that they had been more involved in the care of their family members and that this had improved the quality of the care they received. The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people using the service.

Is the service responsive?

Our findings

Relatives made positive comments about the way staff responded to people's needs and preferences. One relative told us, "If there are any new things they would like to consider they would email me first", "It's much better here than the last place, staff are keen to try new things and it has helped[relative]", "They understand him and they are taking time to learn about his needs." And, "I can come and visit anytime." Relatives felt that staff were approachable and had a good understanding of people's individual needs. They told us people were supported to continue to follow their interests.

Similarly we received positive comments from professionals. Comments included; "I found them responsive and willing to work hard to resolve any issues raised." Another professional told us; "They have adapted [name]'s living accommodation in a person-centred way that is of huge benefit to him. They were fantastic with the transition period and have continued to support him in the best manner possible." And "Communication, updates and feedback is regular and detailed. The support provided is of a very high standard."

We reviewed how the service aimed to provide personalised care. We looked at the way the service assessed and planned for people's needs, choices and abilities. The registered manager and positive behaviour practitioner (PBS) described the processes in place to assess people's needs and abilities before they used the service. We saw examples of the assessments. The assessment involved gathering information from the person and others, such as their families, social workers and health care professionals. Where possible people were encouraged to visit, to see the facilities available and meet with other people and staff. This would help people to become familiar with the service before making a decision to move in. The PBS practitioner informed us they would undertake comprehensive assessments using specialist behaviour assessment tools. This would help them determine if the service and the care staff would be able to meet the person's needs. We found examples where the service had identified a need to train their staff to ensure they could meet the specific needs of a new resident. This was an example of best practice.

We looked at what arrangements the service had in place to ensure people received care that had been appropriately assessed, planned and reviewed. We looked at three people's care files. They were organised, detailed and clearly written. They also included people's personal preferences, life histories, and objectives and achievements. Care staff had full access to this information. People's care plans, were supported by a series of risk assessments. The plans were split into sections according to people's needs and were easy to follow and read.

All three files contained assessments and care plans also known as support plans. There were specialists positive behaviour support plans. The positive behaviour support plans were well written and person centred. The PBS plans were based on the results of functional assessments and used positive behaviour support (PBS) approaches. The plans contained a range of strategies which not only focussed on the challenging behaviours, but also included ways to ensure the people had access to things that were important to them. It was evident that a full assessment of people's needs had been completed before a decision had been made about whether the service could meet that person's needs. Additional assessments

were also evident in some of the files we looked at, for example assessments completed by the Local Authority. This helped to provide a more detailed and holistic assessment of people's needs.

We noted procedures were in place for the monitoring and review of care plans. Care plan reviews were carried out regularly and wherever possible people using the service and their families, if appropriate, were involved. We discussed the importance of ensuring staff reviewed all changes in people's needs to reflect any changes to people's needs.

Daily reports provided evidence to show people had received care and support in line with their care plan. We noted the records were detailed and people's needs were described in respectful and sensitive terms. We also noted records were completed as necessary for people who required any aspect of their care monitoring, for example, weight, falls and behaviour.

People had access to various activities to occupy their time. The provider had employed a 'Skills for Life worker' who was supporting people and other staff with various activities. We noted a schedule of activities had been set for one person including arts and craft, nature walks and drives. Families had been encouraged to come up with ideas to help improve the range of activities offered. We saw that staff had taken people's interests and hobbies into consideration when arranging activities, for example they had attempted to arrange for one person to attend a music festival. Although this was not successful it showed creativity.

The service had a complaints procedure in place. The procedure provided directions on making a complaint and how it would be managed. This included timescales for responses. We saw complaints and compliments guidance was provided to people when they joined the service and was easily accessible. Staff we spoke with confirmed they knew what action to take should someone in their care, or a relative approached them with a complaint. We also saw evidence of one complaint it had been received and how they had been dealt with. The complaints had been dealt with in line with the organisations' policy. This meant that people could be assured that their concerns had been received and acted upon.

Two of the relatives we spoke with confirmed they were aware of the complaints procedure and how to access any information around making a complaint. They told us they were confident should they have any issues that these would be dealt with appropriately.

Is the service well-led?

Our findings

We received positive feedback about the management and leadership of the service. Relatives told us, "The manager is good she listens", "I think they have made some changes in the right direction, I could recommend them."

Feedback from staff was mixed. Three out of five staff were complimentary about the registered manager and the management team. They told us, "[Name] is great as a manager." They told us they were supported to develop their skills to undertake their jobs effectively and felt they could contribute to the development of the service. However, two of the care staff we spoke with raised concerns regarding management's responses to the concerns in the service for example, staffing levels, supervision and the care provided to people. We shared their concerns with the registered manager who informed us they had acted on the concerns raised such as recruitment of more staff and changing arrangement for supervision and improving communication with the team. They also informed us that they temporarily put on hold admission of new people while waiting to recruit more staff.

A professional told us, "I have found the registered manager to be willing and keen to improve the service. They take advice and recommendations on board."

Before this inspection we had received concerns regarding the leadership arrangements at Mather Fold House. Leadership and governance arrangements were unstable due to a high turnover in management personnel. Two registered managers had left the service since April 2016. The service had also experienced high staff turnover, 51 care staff had left the service for several reasons including dismissals or career progression. This had impacted on the quality of care and treatment provided to people who lived at the home. Although there were on going staff shortages and a need for improvements in staffing, we found there were improvement plans in place to further improve the situation. The registered manager informed us that staffing and recruiting the right type of care staff had been their biggest challenge, however they had now started to see improvements and were recruiting the right people.

During this inspection we identified one breach of regulations relating to preventing abuse of service users and we made a recommendation in relation to staff training, supervision and development. This demonstrated that the arrangements for assessing quality and safety required further improvements to ensure they were effective and robust in identifying shortfalls. We also found evidence to demonstrate a lack of a robust questioning culture among the staff team in respect incidents and accidents involving residents. Despite these shortfalls we found the registered manager and care staff at the home were committed to improving the quality of care provided to people. The provider had also committed to ensure standards were maintained.

The service was led by a manager who is registered with the Care Quality Commission. They had been in post for eight months. The registered manager had responsibility for the day to day operation of the service. There was a clear leadership structure in place within the organisation. All staff we spoke with were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any

emergency or concern. There were up to date policies and procedures relating to the running of the service. Staff were made aware of the policies at the time of their induction and when new changes came into place.

Management were committed to their own learning and development to achieve high standards. For example we noted the registered manager had written on their PIR; 'Over the next year we aim to provide more management and leadership training for the senior team of the service. The manager has started a level five leadership and management diploma. The home manager is also sourcing appropriate training for the deputy manager and senior support workers of the service with a view to maximising the skills of the team and being able to provide a continuous positive and progressive service.'

We spoke with the registered manager about the daily operations of the service. It was clear they understood their roles and responsibilities and had an understanding of the operation of the service. This included what was working well, areas for improvement and plans for the future. They were supported in their role by the operations manager, deputy manager, senior care staff, an administrator and care staff. In their PIR the registered manager said, 'The service manager is suitably qualified and experienced with over four years' experience as a registered manager. The service also has a deputy manager and one senior support worker, with three more currently being recruited, who lead shifts of seven support staff. Shifts are arranged at the start of each day by the senior in charge of the shift; tasks are allocated including to meet the needs of the people we support.'

The senior management from the organisation were actively involved in ensuring the service was compliant with regulations and delivering good quality care. We found evidence to demonstrate that there was management oversight from the registered manager. For example, staff with delegated tasks had been supervised by the registered manager and discussions had been undertaken on what was expected of the staff and how progress was going to be monitored. The registered manager was in turn supervised and monitored by the quality improvement manager who visited to undertake quality audits on compliance. Staff had been made aware who they were accountable to. This meant that the service had arrangements in place to ensure staff had clear guidance and lines of accountability.

The registered manager used various ways to monitor the quality of the service. This included daily and monthly medicines audits, and six monthly quality inspections by the quality assessor. There were audits of the systems to manage medicines, health and safety, fire safety equipment, and training, infection control and care files. The audits and checks were designed to ensure different aspects of the service were meeting the required standards. We saw completed audits during the inspection and noted action plans were drawn up to address any shortfalls. In their PIR the registered manager wrote, 'The provider compliance team visit unannounced at least annually to carry out a full bench mark audit, as well as more specific health and safety and financial audits. The regional manager visits on a monthly basis to ensure that the manager and team are working to meet any action plans derived from any of the compliance team audits. Records of all audits are kept, along with details of the action plans, including progress notes and completion dates'. We discussed the importance of ensuring that actions plans had dates to identify when the identified action was to be completed, by who and signed off when completed.

There were quality assurance consultation systems and tools in place. We saw there were policies on undertaking surveys to seek people and their relative's views and opinions about the care they received. However this had not been implemented. However relatives we spoke with informed us that they could share their views anytime. We discussed with the registered manager the importance of formalising this to demonstrate what people's views were and the actions the service was taking wherever suggestions had been made. We found the skills for life worker and other care staff had completed engagement feedback monthly. This was a way that service explored the quality of support people received. It involved exploring

activities that people had engaged in and observing their experiences.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication about people's needs and about the service was robust. We found meetings, were used to keep staff informed of people's daily needs and any changes to people's care and regulations. Staff had been invited to contribute to the agenda for the meetings. Information was clearly written in people's daily records showing what care was provided and anything that needed to be done. We also found a 'handover meeting' system was in place to ensure information relating to people's care was shared between care staff. For example information relating to changes in people's needs.

Monthly practice workshops had been held to discuss people's needs and any improvements that were required. These provided an open forum for staff to reflect on the team's practice. Positives were drawn from these meetings and celebrated within the team. However we found although some bad practice had been identified and noted, action had not been taken in some instances to demonstrate how staff involved would be supported to improve their practice. There was no documented evidence to show how if supervision, performance monitoring or retraining had been offered.

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and related to people who used the service. We found the registered provider had fulfilled their regulatory responsibilities and statutory notifications were being submitted to the Commission. A notification is information about important events which the service is required to send us by law.

We found the organisation had maintained links with other organisations to enhance the services they delivered, this included affiliations with organisations such as local health care agencies and local commissioning group, pharmacies, and local GPs. Challenges associated with other agencies and neighbours had been identified and the service had engaged other services effectively to ensure safe and effective provision of care service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The provider had not adequately protected people against the risk of abuse and improper treatment. This was because the systems and processes for monitoring acts intended to control or restrain a service users to prevent harm, were not always robust.</p> <p>The provider had failed to ensure that all care staff had received induction and training that is relevant to their role and at a suitable level to make sure any control, restraint or restrictive practices are only used when absolutely necessary, in line with current national guidance and good practice, and as a last resort.</p>