S.E.L.F. (North East) Limited

S E L F Limited - 14 Park View

Inspection report

14 Park View
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Houghton Le Spring
Tyne and Wear
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Tel: 01915268565

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 8 February 2018 and was unannounced. This meant the provider and staff did not know we would be coming. The inspection was planned partly in response to concerns raised with the Care Quality Commission (CQC) about the management of a recent safeguarding concern.

We previously inspected SELF Limited - 14 Park View ('14 Park View') in September and October 2015, at which time the service was meeting all regulatory standards and rated good. The service was rated requires improvement at this inspection.

14 Park View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. 14 Park View provides care and support for up to nine people who have a learning disability. Nursing care is not provided. There were nine people using the service at the time of our inspection. The registered provider operates three separate services at Park View (numbers 14, 15 and 16). During this inspection we inspected all three services. Although the services are registered with the CQC individually we found that there were areas that were common to all three services. For example, training programme and delivery, joint staff meetings and one set of policies and procedures across all three services. For this reason some of the evidence we viewed was relevant to all three services.

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

The management of a recent safeguarding concern was not robust in terms of establishing clear outcomes, nor was the investigation process sufficiently accountable.

Risk assessments did not always set out clearly enough how to protect people who may be at risk of absconding, or at risk of harm from others.

Medicines administration practices were not always in line with good practice and opportunities had been missed to improve these practices.

Auditing processes had not identified some of the areas identified on inspection and the provider needed to review how they managed the auditing of the service in the longer term, both in terms of the efficiency of individual audits and who these responsibilities may in time be delegated to.

Staff did not always ensure confidential information was appropriately locked away, or that keys to the medicines storage units were securely stored.

The majority of risk assessments were sufficiently detailed with clear strategies in place for staff to help protect people in a way that also did not unnecessarily restrict them.

People who used the service interacted well with staff and told us they felt safe. No relatives or external professionals we spoke with raised concerns about safety.

There were sufficient numbers of staff on duty to meet people's needs and staff were aware of their safeguarding responsibilities.

All areas of the building were clean and processes were in place to reduce the risks of acquired infections. The registered manager agreed their response to a flood in a bathroom could have had more regard to people's individual hygiene. The premises were generally well maintained, with external servicing of equipment in place.

Pre-employment checks of staff were in place, including Disclosure and Barring Service checks, references and identity checks. These checks were refreshed after three years after external advice.

The ordering, storage, administration and disposal of medicines was generally safe, although we identified areas of poor practice with regard to creams and the administration of 'when required' medicines.

People had accessed external healthcare professionals such as GPs, psychiatrists, nurses and occupational therapists to get the support they needed. Staff liaised well with these professionals.

Staff received a range of mandatory training and training specific to people's needs.

People were encouraged to have healthy diets and were protected from the risk of malnutrition, with staff adhering to external advice from dietitians.

The premises were appropriate for people's needs and there were ample communal areas and bathing facilities.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Relatives and external professionals confirmed staff had formed good relationships with people, in part thanks to a continuity of care and a keyworker system.

People were encouraged to access their local community, which reduced the risk of social isolation.

The atmosphere at the home was communal and relaxed. Person-centred care plans were in place and regular house meetings took place. Care plans were reviewed regularly with people's involvement.

The service had good links with a local farm, stables and college, and people pursued a range of activities and hobbies meaningful to them.

People who used the service, relatives and professionals we spoke with gave positive feedback about the hands-on approach of the registered manager and the personal interest they took in ensuring people's day to day goals were met. The registered manager and staff had maintained a caring, person-centred culture within which people were supported to develop their independence.

We found the service was in breach of regulation 12 (Safe Care and Treatment) and regulation 17 (Good Governance).

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

A recent safeguarding concern had not been managed or documented appropriately.

Staff did not always adhere to policies relating to the security and confidentiality of personal sensitive information.

People who used the service and relatives had confidence in the ability of staff to keep people safe and staff demonstrated a good knowledge of safeguarding principles.

Risk assessments were generally detailed and person-centred, although improvements were required regarding risk assessments relating to people at specific risk of absconding or those people at risk from others.

Is the service effective?

Good

The service was effective.

Staff worked well with a range of healthcare professionals to ensure people's health and wellbeing was maintained and care planning was well informed.

Staff had recently received Mental Capacity Act 2005 training and Deprivation of Liberty Safeguards we saw were appropriate.

People enjoyed a range of meals and staff acted on the advice of dietitians to ensure people's nutritional needs were met.

Is the service caring?

Good

The service was caring.

The atmosphere was calm and relaxed, with positive relationships between peers and between staff and people who used the service.

Staff demonstrated caring and patient behaviours during the inspection and relatives confirmed staff behaved in this way

consistently.

Staff communicated well with people and had regard to their varying communication skills, preferences and levels of independence.

Is the service responsive?

Good

The service was responsive.

Staff liaised proactively with external professionals when people's needs changed or when advice was needed.

People who used the service pursued a range of hobbies and activities meaningful to them and regularly accessed the local community.

Regular residents' meetings and a keyworker system meant people who used the service could raise queries or concerns via a range of means.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Auditing was not always effective and did not always identify where service provision could be improved. Action plans were not always sufficiently detailed or measurable.

Accidents and incidents were responded to appropriately although were not recorded in such a way that allowed for a meaningful analysis of them.

Staff and people who used the service spoke positively about the registered manager and they demonstrated a passion for ensuring people received a good quality of care.

The registered manager and staff had successfully maintained a culture that focussed on people's potential to have better health and wellbeing outcomes.

S E L F Limited - 14 Park View

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.

We visited the service on 8 February 2018 and the inspection was unannounced. We do this to ensure the provider and staff do not know we are coming. The inspection team consisted of two Adult Social Care Inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

We also asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

During the inspection we spent time speaking with six people who used the service and observing interactions between staff and people who used the service. We spoke with seven members of staff: the registered manager, the director and five care staff. We spoke with one visiting healthcare professional. We attended a staff meeting. We looked at four people's care plans, risk assessments, medicines records, staff training and recruitment documentation, quality assurance systems, a selection of the home's policies and

procedures, meeting minutes and maintenance records.

Following the inspection we spoke with two relatives of people who used the service and four external professionals.

Requires Improvement

Is the service safe?

Our findings

The registered manager had not conducted an internal investigation in a sufficiently robust manner. We saw they had interviewed all relevant members of staff and people who used the service but the investigation report was not clear about what the allegations were, what evidence was pertinent and proven, and what the outcomes were. The provider's safeguarding policy references the balance of probabilities (whether something is more likely than not to have happened) but the registered manager in this case did not make any findings in their investigation. This meant the investigation process was not accountable and open to scrutiny. It also meant the alleged incident and how it was managed could not be effectively used to learn lessons and improve how the service kept people safe in the future. The registered manager had initially acted on the basis of allegations being unproven, rather than acting on those allegations in a balanced way, prior to coming to any findings. Again, this was contrary to the provider's safeguarding policy.

We found a range of risk assessments in place, which were specific to people's individual needs and had regard to promoting people's individual freedoms. Some risk assessments and relevant actions in place were not sufficiently detailed. This was in relation to the potential risk posed by people leaving the premises, moving between the provider's other locations, or the risk of people from outside the location entering the premises. One person was at particular risk of harm and there were no safeguards in place to monitor people entering the premises from outside or, equally, to monitor the whereabouts of this person given they were particularly susceptible to risk. The registered manager and provider agreed to address this specific area of risk.

We reviewed the arrangements for the storage, administration and disposal of medicines and found, whilst this was generally safe and there were areas of good practice, there were areas of improvement to ensure all practices were in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

We found no errors in the medication administration records (MARs) we reviewed but, on sampling topical medicines (creams), we found instructions were not always clear regarding where to apply the cream. One member of staff confirmed they would ask a more experienced member of staff for advice regarding how to administer the cream. The registered manager confirmed they did not use body maps for this purpose but that they would begin this practice to ensure people received prescribed creams appropriately. Where people needed medicines on a 'when required' basis (including creams) we found staff had at times written additional information on the medication records regarding how and when these medicines may be required. The registered manager told us they were in talks with the pharmacy provider to ensure this information was on the MAR at the point of prescription. We noted the keys to the medicines storage cupboard were at times left in the office, which was unlocked. This was also poor practice and meant there was a risk the medicines could be accessed by someone other than the responsible member of staff.

This meant some medicines practices at the time of inspection were not in line with good practice guidance issued by the National Institute for Health and Clinical Excellence (NICE) and required improvement.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

The rest of people's individualised risk plans we saw did make it clear to staff the types of prompts or triggers people may display before behaving in a particular way, and plans were detailed in their instructions to staff regarding coping and de-escalation and distraction strategies. Where relevant, people had 'mood logs' or 'anger logs' in place which staff completed to identify if people's patterns of behaviour changed over a period of time. These were then shared with other professionals, who then liaised with multi-disciplinary colleagues and the registered manager to agree the best means of keeping people safe. One professional spoke to us about a person who used the service who they worked with regularly, and the approach of staff: "[Person] has flourished here – they interact well with the others here generally and staff do things proactively." One example of this was encouraging a person's family contact, as this was known to calm them and be a positive influence on their wellbeing and safety.

Premises and equipment were appropriately maintained, with contracts in place to ensure equipment was serviced to ensure safety. This included gas appliances, electrical installations and fire alarms and fire-fighting equipment. Portable Appliance Testing had been completed and the periodic electrical inspection was planned to be completed shortly after the inspection visit. The premises were clean throughout and people who used the service and visitors confirmed this to be the case more regularly.

We saw one bathroom was out of use due to a flood. The registered manager told us this had occurred in the past two days and we noted it had been repaired by the end of the inspection. During the repairs there was however no running water. We asked the registered manager what contingency measures they had taken and these amounted to filling containers with water so that toilets could be refilled and kitchen duties completed. There were no alternative hand washing means provided, such as alcohol rub or disinfectant wipes. The registered manager acknowledged they could have put in place more effective contingency measures.

Staff had completed specific training intended to better enable them to keep people who used the service and themselves safe, for example fire awareness training and safeguarding training. When we spoke with staff about how to identify signs of abuse and what to do if they had concerns, they were consistent in their responses and felt supported to raise concerns if they had them.

We observed people interacting in ways that demonstrated they were comfortable in their surroundings, with other people who used the service, and with staff. People told us, "The staff help me to feel safe" and, "having the staff around to look after us makes me feel safe." Relatives told us, for example, "We've seen masses of improvement. He was a real challenge to calm but they have succeeded," and "It makes such a difference knowing they're safe."

A range of external professionals we spoke with were positive about the levels of person-centred risk management the service provided to people who used the service, some of whom had a forensic background. One professional told us how impressed they were with how the service managed people's vulnerabilities as well as the risks they may have posed, saying, "I have a great relationship with this service and feel the management get the balance just right."

The registered manager had a proactive relationship with police liaison representatives in this regard and we saw they had recently invited police to speak with a person who used the service to ensure they understood what behaviours were and were not acceptable. The registered manager met with the police every two weeks to try and manage or anticipate risks.

Recruitment processes continued to be followed for new staff to ensure suitable staff were employed. All necessary checks were carried out for each new member of staff including two references and disclosure and barring service checks (DBS) prior to someone being appointed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with children and vulnerable adults. The provider had recently introduced a three-yearly refresh of these checks, on the advice of the local authority, to help ensure staff who had been at the service a number of years remained suitable to work in the service.

We found there were sufficient care staff on duty to keep people safe and meet their needs, day and night, and staff worked well as a team. Rotas demonstrated a consistent level of staffing and people who used the service and their relatives confirmed there was always sufficient staff available. Staff also raised no concerns in this regard, stating, "There is always a good level of staffing," for example.

Good

Is the service effective?

Our findings

Records showed that staff had completed a range of training in areas such as safeguarding, Mental Capacity Act 2005 (MCA), moving and handling, fire safety, first aid and food safety. Staff had also completed training specific to people's needs including epilepsy, diabetes and dysphagia (when a person has difficulties swallowing). When we spoke with staff they demonstrated a good knowledge of people's needs and told us they found the role of keyworker a rewarding one. People who used the service told us, for example, "They all know us and read our files."

Staff received regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff received three supervisions a year and an annual appraisal. Records of these meetings showed they were used to discuss any particular support needs the member of staff had, as well as areas of practice such as behaviour management, medicines and infection control. Staff told us, "You are well supported," and, "The induction was a full one and you have time to get to know people and what tasks you have to do."

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection two people were subject to DoLS authorisations. These were clearly recorded and monitored to ensure the registered manager applied for new authorisations in good time should they be necessary. Where possible people had consented to their care and had signed care plans to show this as well as specific consent forms. Staff had received training in the MCA and DoLS. Where people who used the service did not agree with a restriction on their liberty (for example, a DoLS) and wanted to formally challenge this, we saw they had not been impeded by the service in any way and the registered manager ensured they had access to advocacy services to support them where needed.

People were supported to meet their nutritional needs. We spoke to staff about menus and were informed that there are two choices on a lunch and tea time for people to choose between. Staff explained that people were asked their choices prior to each mealtime and that other options were available for people if they didn't want either of the two planned choices. One person told us the food was often the same but we found this was not the consensus of opinion. One person told us, "Yes, I like the meat and potato soup," whilst another said, "The food is nice because they make it especially for us."

Most people helped prepare meals in the home on a rota basis. There were rotas on display in the kitchen in

pictorial format to inform which person would be assisted by staff to prepare lunch and tea time meals. Staff told us this helped to increase people's independence and give them a sense of responsibility.

One person had been referred to a dietician due to not eating much which had resulted in them losing weight. The dietician recommended the person be given fortisips every day. These are high-protein drinks intended to help people gain weight. Care records showed this was put in place and the person was being monitored and weighed regularly. A food diary was being kept which recorded their daily intake of food and a review with the dietician was going to take place after six weeks of support. One person we spoke with keenly enjoyed baking and confirmed staff supported them to pursue this interest. We saw them experimenting with waffles during the inspection and sharing these with other people who used the service.

People were supported to access external professionals to monitor and promote their health. People's care plans contained records of involvement with GPs, dentists, opticians and other professionals involved in their care. We found people were supported to achieve good health and wellbeing outcomes thanks in part to the timely involvement of these professionals. We saw evidence to support this, for example, in one persons' file, "[Person] has continued to display significant improvements in his presentation and behaviour." One external professional told us, "They have really thorough treatment plans in place and they follow them," whilst another told us about how staff helped to proactively minimise a person's hospital admissions and, in conjunction with a multi-disciplinary team, "developed clear plans for the service user which attempted to maximize his independence and minimise the risks to others."

Staff meetings were held regularly and minutes of these meetings detailed a broad range of discussion points such as safeguarding, rota, professionalism, training and updates regarding individual's needs. We attended one team meeting and found staff demonstrated an ability to share important information appropriately.

Good

Is the service caring?

Our findings

People who used the service told us, for example, "When they [staff] are free they will have a chat with you", and "I can sit and talk to staff when I am not happy and I can tell them what's upsetting me as well". Another said, "It's nice, very friendly here. They make birthday cards for you." We found staff knew people well and had built strong relationships with them. People were assigned a keyworker and we found these staff demonstrated a good knowledge of the person's individualities and preferences. Care plans contained good levels of information regarding people's preferences and wishes.

We found there to be a homely feel to the service where people interacted well with their peers and staff. We found this had a positive impact on people's wellbeing. Relatives told us, "It's quite a communal feel," "They get on well with the others there – they have friends," and "They are so calm now – it has made a real difference." During our observations people interacted with each other well, for example playing board games and chatting with others and staff.

Relatives and external professionals we spoke with were all complimentary about the caring attitudes and behaviours demonstrated by staff. Relatives told us, for example, "The staff are excellent - I can't fault them at all," and "It makes such a difference knowing they are so well cared for." We observed staff treating people with respect and patience throughout the inspection, valuing their choices and the fact they may change their mind. Staff understood that people who used the service had differing levels of independence, and were mindful of this when asking people what they would like to do or encouraging them to take part in activities.

We found the registered manager had acted as an advocate for people's rights and was passionate about them receiving positive outcomes, liaising with a range of health and social care professionals. When we spoke with these professionals they confirmed the staff and leadership focus at the service was to support people's independence as much as was practicable whilst also keeping people safe. One person who used the service was in the process of moving to a more independent living environment, having been supported to improve their daily living skills and confidence.

Staff displayed genuinely caring attitudes and behaviours. Where one person who used the service had to go into hospital, we saw the registered manager and staff had ensured the change and the anxieties it might bring about were minimised as much as possible to support the person's wellbeing. For example, a rota was planned for staff to visit the person to ensure they had a continuity of support, whilst the registered manager also ensured they had access to their favourite music whilst in hospital.

Where people who used the service were in a relationship we saw this was respected and encouraged through staff taking an interest. For example, one person had returned from a holiday with their partner and they enjoyed talking about the experience with the registered manager as well as bringing back a gift. There was a genuine warmth and care in these interactions. Where people were in contact with family members we saw this was encouraged and facilitated. One person told us, "I go to see my sister on a Sunday – a member of staff takes me."

People who used the service told us they were involved in their own care planning and review, and that staff asked them regularly if they were meeting their needs. Regular service user meetings were held as a means of ensuring people had a forum in which they could raise concerns or queries. Relatives confirmed they were also involved in care planning and review. Where one relative lived abroad we saw the registered manager and director had communicated with them regularly by email and also planned phone calls to ensure they were updated.

Care plans contained detailed information about how best to communicate with people on their terms and how to ensure staff did not trigger or raise anxieties in people. For example, speaking more slowly to people or giving them specific activities as an alternative if they were distressed. When we spoke with staff they displayed a good knowledge of how to communicate with people and we observed numerous examples of this during the inspection.

People's rooms we saw were well decorated and personalised, for example with pictures, memorabilia and their own belongings.

Good

Is the service responsive?

Our findings

We saw that before people started using the service assessments of the support they needed were carried out, covering, amongst other things, mobility, dependency and eating and drinking. As well as people's physical needs these assessments also covered people's family history and religious beliefs and practices. The registered manager told us, "We do an assessment before anyone moves in. Then the previous provider come and do a workshop with us." They went on to say, "We have a new service user moving in soon so we'll have a chat about them (with staff)."

This pre-assessment and how information was shared with staff differed for each person who used the service. For example, the registered manager was aware that one person due to use the service may present particularly complex behaviours. To ensure staff were well prepared for this they had arranged for a social care professional to visit the service and deliver an awareness session to staff.

People had a range of care plans in place to meet their needs, which had been identified from their assessments. Care plans were personalised and included peoples' choices, preferences, likes and dislikes.

Care plans were detailed and contained clear directions to inform staff how to meet the specific needs of each individual. Records showed care plans were reviewed on a regular basis and in accordance with people's changing needs. All care plans we reviewed were up to date and reflected the needs of each individual person.

People had individual activity programmes in place to help them develop practical skills such as self-care to improve their independence and boost their confidence. Programmes also contained activities to suit people's hobbies and interests. The registered manager showed us around the home and we observed a quiet room on the first floor which contained a television and sofas amongst other things. The registered manager told us, "Sometimes the lads come in and play on the Playstation (computer game system)." They also informed us that some people regularly attended football matches on the field opposite the home.

Other popular activities that people had access to included going into town shopping and visiting the nearby farm and stables. One person told us, "I like colouring in and I go to the shops. I like to go to Washington Galleries." Another said, "I am never bored here, I always have something to do", whilst another said, "At the farm I am making benches and tables from wooden pallets and I go to the farm to look after the horses."

The approach to activities and care planning was person-centred and had a regard to people's choices. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. One person told us, "I am more independent here and I can do my own things."

During our tour of the home we observed people playing a game with staff members. They were happy and smiling and chatting with staff. They also greeted us when we entered the room.

At the time of our inspection no one at the service was receiving end of life care. Records showed that initial discussions had taken place with people, although some did not want to have detailed plans around end of life care at that time. The registered manager informed us that they had supported a person receiving end of life care previously. They explained how they had worked with district nurses and a GP and how the person was monitored and supported during that difficult period. The registered manager said, "We worked with the district nurses. They came in three or four times a day and we closely observed [person]."

We saw evidence that the registered manager and staff liaised promptly and regularly with external professionals when people's needs changed, or when further support or advice may be needed. We spoke with some of these professionals who agreed staff members kept them updated and appropriately raised questions or concerns with them in a timely manner. One said, for example, "They work really well with us. I wish there was more providers in the community like SELF…partnership work is so important.

With regard to complaints, there had been none recently and no one we spoke with raised concerns. People who used the service and relatives confirmed they knew how to raise any concerns they may have, and who to raise these with.

Residents' meetings took place regularly, at which people who used the service could discuss the planning of future activities, menu options, and any concerns they may have. People we spoke with were also confident they could raise any concerns with their keyworker.

Requires Improvement

Is the service well-led?

Our findings

Auditing processes required improvement. Some areas of risk and poor practice had not been identified by the auditing processes in place, for instance the areas of improvement required in medicines administration, and the lack of clear practices in place to manage specific risks to a person who was at risk of absconding.

Auditing processes were completed by the registered manager, who also conducted the majority of audits for the adjacent service they were also the registered manager for, as well as some of the auditing for the provider's other service, located across the car park. The audits were monthly and included health and safety, maintenance, medications and Control of Substances Hazardous to Health. We found, whilst they had maintained a level of oversight across all three services, this was not a practical or manageable means of ensuring service provision was maintained to a high standard in the longer term. Both the registered manager and director told us some of the registered manager's duties would be appropriately delegated when new 'Head of Care' positions were filled. The provider's intention was to have a Head of Care at each of the three locations to ensure there was sufficient leadership and managerial support. At the time of inspection two of the three planned posts had been filled, although the staff had yet to begin work.

In addition to onsite auditing there was a regular visit by another company director, who undertook a range of checks. These included health and safety checks such as whether fire routes were clear, infection control standards, maintenance issues and water temperatures. They also reviewed care plans and staff files to see if there were any concerns or patterns evident. With regard to medications, this audit, completed in January, did have a section entitled 'medication file/stock' with a 'yes' box ticked. It was unclear what information this audit had reviewed in terms of medications.

We saw the registered manager and director had been aware of the areas requiring improvement with regard to medicines in October 2017 and that they had included them in an ongoing action plan. The target date for completion was April 2018 but the improvements required could and should have been implemented in a much shorter space of time and were relatively simple to address, for example using body maps when administering creams, and improving 'when required' care plans. This meant the quality and safety of the service was not always improved in a timely way.

We also found accidents were recorded individually but they were not stored centrally by the registered manager. There was an accident book, but this had not always been completed. This meant the means of identifying patterns of accidents and incidents was more difficult and that information was not always accurate and up to date.

Opportunities to improve and learn from previous identified practice shortfalls had not yet been taken, and advice had not been acted on in a timely fashion.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

We reviewed the service's overarching 'Mission Plan/Action Plan' for 2018 and found it to be lacking in detail and dates for individual actions, against which to monitor progress. Whilst the general goals in the plan were positive, it was not a plan against which performance could be effectively measured at the end of the year.

People who used the service interacted well with the registered manager, who demonstrated an excellent knowledge of the needs of people who used the service. One professional told us, "I think people have a fantastic relationship with the registered manager," and another said, "[Registered manager] is a credit to the organisation and always keeps me involved."

The majority of records we reviewed were accurate, up to date and person-centred. The registered manager had been in post for a number of years and had relevant experience. Staff we spoke with gave consistently positive feedback about the registered manager's hands-on approach to the service and the support they gave staff in fulfilling their roles. One staff member told us, "The manager is great. They care about people having a quality of life," and another said, "You can go to them with any problems…you are fully supported."

Staff meetings were held regularly as a means of ensuring information was shared and there were additional forums in which to raise any queries. We found evidence that the registered manager actively made themselves accountable to staff and was open with external agencies when it was appropriate to share information externally. The registered manager and director displayed a lack of knowledge in some aspects of when they would need to notify CQC of relevant events and agreed to review relevant guidance on this matter to ensure they notified CQC of appropriate events.

Good community links were in place, particularly with a local college, stables and farm and football club, all of which enabled people to engage in a range of activities meaningful to them. The registered manager had ensured people were able to access their community in a positive, meaningful way, and that they were protected against the risks of social isolation.

Turnover of staff was relatively low and staff morale was good, both with new staff and more experienced members of the team. We found staff had helped to deliver the person-centred service the leadership aspired to provide, with a focus on helping people achieve levels of independence within a homely and supportive environment. The openness and communal nature of the culture and atmosphere was a positive factor in the feedback we received, but the registered manager and provider needed to ensure the risks associated with such openness, for example people being able to move between all three locations, given the particular risks people who used the service faced, were more closely managed.

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 The provider did not have sufficiently detailed risks assessments in place for people at risk of absconding. Topical medicines and 'when required' medicines were not appropriately documented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Auditing processes had not ensured poor practice was improved and lessons learned, particularly with regard to the management of risk and medicines.