Care Quality Commission

# Atlas Healthcare Limited

# Huntercombe House

## Inspection report

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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 |

## Overall summary

Huntercombe House provides accommodation to up to 21 people living on two floors. On the ground floor people were cared for in their own bedsits with each bedsit having kitchen and bathroom areas. On the first floor people had their own bedrooms with en-suite facilities. Meals were provided to people upstairs by a central kitchen. There was also a training kitchen where people could make their own meals. People who lived at Huntercombe House had learning disability and mental health needs. They were personally supported each day by one or two members of staff allocated to work with them.

This inspection was unannounced and took place over a period of two days on 2 and 13 August 2014. At our last inspection in December 2013 we found the service was compliant.

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. At the time of our inspection the registered manager was

# Summary of findings

not working in the service. An acting manager had been appointed to support and run the service. The acting manager had identified a number of deficits in the services and had developed a plan to improve the service. The service is also supported by a multi-disciplinary team which includes a consultant clinical psychologist, an assistant psychologist and an occupational therapist.

We found people had care plans and risk assessments in place which reflected their individual needs. People told us they felt safe living at Huntercombe House and we found there was enough staff to meet people's needs.

We saw some areas of the home were not clean and the risk of cross infection had not been minimised by the registered provider. We asked the registered provider to address this issue.

Staff were able to tell us about people in their care including their likes and dislikes. One relative told us they found the staff to be 'extremely helpful and caring'

We found the registered provider had responded to family concerns and had taken action when concerns had been raised. They had invited family members into the service to attend meetings and find ways of improving the service for people.

The acting manager had put into place a steering group to improve the service including the development of a new service model, recruitment of staff and staff training. The steering group had reviewed their progress and actions had been taken by group members to make progress.

We looked at three people's daily records and found not all of the daily records matched the requirements of people's care plans. We found action had been taken to put in measures which would address these shortfalls and discussion with staff had taken place to improve.

We found the registered provider did not have in place regular monitoring of people's weights to ensure their dietary requirements were effective. However, we saw they had put into place actions to support people to lose weight or eat healthily.

We recommended that the registered provider continued to explore and address the shortfalls they had identified in the service.

We found one of breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the back of the full version of this report.

# Summary of findings

## 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.

We saw people had in place care plans and risk assessments which were pertinent to them as individuals. People told us they felt safe at Huntercombe House.

We found areas of the building were unclean and the risks of cross infection had not been minimised.

We found the registered provider had ensured there was sufficient staff on duty to be able to care for people which met their required level of assessed need.

We found the registered provider had considered each person's ability to make their own decisions and had in place mental capacity assessments.

**Is the service effective?**

Requires Improvement

The service was not always effective.

We found some people were expected to have undertaken cooking activities during each week and these were not documented. Arrangements had been put in place by the multi-disciplinary team which ensured these were monitored.

People told us when they were not well staff made the necessary arrangements to seek medical attention. People could tell us about their appointments and understood what was going to happen.

We found staff supervision arrangements had been adhoc and new arrangements had been put into place. Staff had signed new supervision agreements.

We saw the registered provider did not have in place regular monitoring of people's weight to ensure their dietary requirements were being met and people were not losing weight unnecessarily.

**Is the service caring?**

Good

The service was caring

We found the staff spoke to people in a caring way and explained to people what was happening. We saw people were relaxed in the company of their staff.

Staff supported people to talk to the inspection team and stayed at a respectful distance until the people needed support to explain what they wanted to say.

# Summary of findings

Staff were able to tell us about each person's likes and dislikes and their preferred routines.

**Is the service responsive?**

Good

The service was responsive.

We found the manager had responded appropriately to complaints, offered solutions and invited a family to make suggestions to change the situation.

We saw the service had responded to concerns raised by family members and had either undertaken an assessment or brought people together in a meeting to address the concerns.

The service had in place keyworker meetings where people's plans and risk assessments were discussed on a regular basis and updated to meet people's needs.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

We found the manager had put in place a steering group to support and direct service improvements. The steering group had an action plan and progress was being made towards the agreed actions.

We saw the service had in place a multi-disciplinary team (MDT) meeting to review people's planning and address their needs. We found further work was required to ensure the outcomes of the MDT were more closely linked with front line practice.

We found the service had commissioned an independent advocacy service to run a family survey and to seek feedback from family members

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

The inspection team for this service consisted of two adult social care inspectors and an 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 care service.

Before our inspection we reviewed all the information we held about the service. We reviewed the notifications made to the Care Quality Commission by the provider. We considered the nature of safeguarding alerts that had been made and any other information that had been shared with us. We were not aware of any additional concerns from the local authority commissioners. We asked the registered provider to complete a pre-inspection Provider Information Return (PIR) and used this to inform some of our planning.

The inspection took place on the 12 and 13 August 2014 and was unannounced. At the time of our visit there were twelve people living at Huntercombe House. Over the two days of our inspection we spoke with five people living at the service. We undertook informal observations of care in the communal areas and people's bedsits. We looked at all areas of the home and spent some time looking at documents and records that related to people's care and the management of the home. We looked at five people's care records. We also spoke with eight staff and reviewed the records of five staff. Following our visits to the home we spoke to four people's relatives and two other professionals who visited the home.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

# Is the service safe?

## Our findings

People we spoke with told us they felt safe at Huntercombe House. One person told us they knew who to go to if they had any concerns and were confident things would be sorted out. One person's relative told us they were "very satisfied with the service".

We looked at cleanliness and infection control during our inspection and found there were areas of the building which were not clean. When we looked at the cleaning schedules for the building one staff member told us, "It's a bit higglety pigglety" and they explained that the cleaning regime had changed. We saw that the cleaning schedules were incomplete. We showed the acting manager our cleanliness concerns in the building. The acting manager told us they had changed the working hours of the cleaning staff earlier in the year. This meant staff were not able to routinely record what they had cleaned on the existing schedules. We found the provider did not have in place an effective cleaning system designed to prevent and control the risk of infection.

One family member drew our attention to one person's room we found their shower was stained brown in the corners. We saw there were rusty metal toiletries' holders and the toilet was stained? brown. The joins in the pipe work for the showers were dirty with a green substance built up around the joins. We found similar areas of concern in other bathrooms. In one bedroom we saw the edging around the shower was brown and the underside of the shower sheet was also stained brown and rusty.

We looked at people's bedsits and their kitchen areas. In one person's room we found the sink and cooker to be dirty and the flooring around the edges to be ingrained with dirt. We looked at the laundry area and found there was no flow in place from dirty to clean laundry. All of the washing came in one door and the registered provider had not ensured left by the same route which meant there was an increased risk of the spread of infection. There was no dirty to clean route identified in the laundry. This meant that there was an increased risk of the spread of infection.

We found the registered provider was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at five people's care and support files including care plans and risk assessments. We found that where a risk had been identified staff had undertaken a risk assessment. For example, staff had completed risk assessments in relation to nutrition, accessing the community and self-care. There were also specific risk assessments documented where people undertook activities specific to them, such as volunteering. We found the risk assessments included the risks people might face and provided guidance about what action staff needed to take to reduce or eliminate the risk of harm. For example, we saw detailed guidance had been provided for staff about how to support one person if they had an epileptic seizure.

We looked at the records for one person who had a sleeping disorder. We found that they had been diagnosed by a health professional and were expected to wear a mask during their sleeping hours. We saw from the person's care plan that staff were expected to record the use of the mask and how many hours the mask was used for during the night. We found that no evidence that records had been kept to monitor this person's use of their mask during the night.

We looked at the arrangements for people's medicines and saw the registered provider had a medication policy. We found that medication was kept in an air conditioned room in locked cupboards. We saw that each person's medication had been dispensed by the pharmacy in a bio-dose system. This meant the pharmacist had put people's medication into a box divided into different times of the day. We looked at people's medication administration records (MARs). Out of the twelve people living at Huntercombe House we found one gap in one person's MAR and three gaps in another person's MAR. These gaps had been noted by the provider and action taken to prevent re-occurrence. Fridge temperatures were recorded daily to ensure medicines which needed to be stored below a certain temperature were appropriately stored. We saw when people go on home leave or on other outings their medication is booked out and then booked in again on their return.

We saw that people received their medicines safely and found the registered provider had in place suitable arrangements for people's medicines which protected them against potential risks of medication misuse.

We looked to see if staff were safely recruited and reviewed five staff records. We saw that prospective staff completed an application form. We raised concerns with the acting

Requires Improvement

# Is the service safe?

manager about one application form where the staff member's relative worked at the service and had been involved in their application. The person's application form was incomplete and there was only one reference on file. Out of the remaining four staff records we looked at, one person did not have an application form on file. None of the references we saw had been verified by the previous manager. The acting manager explained that they had introduced a new recruitment process to make the process more robust and they had recently addressed our concerns This involved a two stage interview process where applicants were given scenarios to discuss what they would do. We saw these scenarios had been used with one person who had been recently recruited to assess if they had the right experience and aptitude for the work. We saw the registered provider had ensured staff had Disclosure and Barring Service checks in place before they started employment. This meant the provider had checked staff were safe to work with vulnerable people.

We found the registered provider had ensured there were sufficient staff on duty to be able to care for people. We checked staff rotas to see if there were sufficient staff on duty to meet people's needs. Staff told us they were allocated people to care for each day on a 1:1 or 2:1 basis. We saw daily allocation sheets recorded which member of staff was looking after which person and found where people were required to have two staff to care for them, there were two care staff in place. Staff told us who they were looking after that day and what activities they were doing.

We observed staff moving around the building with the service users they were supporting for the day. We saw there were frequent conversations held with each person and no one was resistance to their staff member supporting them. When people went into their bedrooms staff waited outside the door. This meant people were able to be kept safe by constant supervision but could also keep their private space.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We saw policies and procedures were in place and the acting manager was able to explain the procedure for submitting an application to the local authority. We found the registered provider had considered each person's ability to make their own decisions and had appropriately submitted applications for DoLS. We looked at people's files and saw there were best interests and mental capacity assessments. In one person's file we saw the mental capacity assessment had been carried out by a psychiatrist working with the person and staff had been told, "If (the person) expresses interest in any activity this should be brought to keyworker meetings." This meant the registered provider had recognised the person may not be able to make decisions about their activities which kept them safe.

We talked to staff members about how they dealt with behaviour that challenges the service or others. They gave us examples of behaviour which challenges the service and how they would respond to it. One staff member said they use a system of consequences and rewards and it is different for each person. They told us one person "Is rewarded with chocolate because this is what they have always been rewarded with." Staff told us restraint was used as a last resort with people and only if people are going to hurt themselves or someone else. They also told us they try to diffuse the situation by sitting down with people or encouraging them to go to along to their bedrooms. Staff told us they used techniques which were appropriate to calm behaviour that challenges the service. We found the techniques staff described to us to calm people's behaviour were documented in people's care plans.

We also looked at how the building and the equipment within it were maintained. We saw outside of the maintenance office there were blank maintenance report forms for the staff to complete if they needed to report a maintenance issue. The maintenance staff confirmed to us that care staff completed these and left them for their attention. The maintenance staff also told us that they prioritised their tasks and where they were unable to repair or replace an item they sought quotes to have it replaced. We found the service kept clear records of maintenance required and where equipment such as hoists and wheelchairs required servicing these were done in accordance with the manufactures instructions. We saw fire checks were in place and were carried out on a regular basis.

Requires Improvement

# Is the service effective?

## Our findings

We spoke with people who used the service and one person told us they went to college, had done a DJ course and volunteered with a local animal charity. They told us they do their own skills (household tasks). Another person told us they cooked Spaghetti Bolognese, ravioli, spaghetti and egg on toast, stir fries and sausage and mash. We found the service was able to develop people's skills. One family member told us their relative has a good quality of life at Huntercombe House and described their relative's activities including 'going to the pub'.

We compared three people's care plans with their daily records over the period of the fortnight prior to our inspection. We found the daily records supported people's assessed needs. However, we also found some activities in people's care plans had not been carried out. For example, in one person's care plan we found they were expected to have two cooking sessions per week in the training kitchen. We found no cooking sessions had been documented. We also found this pattern was repeated for another person. A member of the multi-disciplinary team (MDT) told us they had identified this issue and introduced activity records to measure and address activity levels. We saw staff were expected to complete activity records to say what tasks people had undertaken each day. Staff confirmed to us they completed these records The MDT member told us the activity records were collated in the Occupational Therapy Activity report and then fed back to staff. This meant staff were appraised of what was required to continue to meet people's assessed needs.

We saw the Occupational Therapy Activity the report dated 28 July 2014 and we read out of eight people seven had achieved 50% or less of their prescribed cooking sessions. This meant the provider had begun to measure the effectiveness of the care plans and was working with staff to improve the effectiveness of the service.

During our inspection we attended the in- house multi-disciplinary team (MDT) The MDT meeting consisted of a consultant clinical psychologist, and assistant psychologist, and occupational therapist and representatives of people's care team including the manager. The team members told us people are welcome to attend but most refuse and they are represented by their care staff. We listened to the discussion. The outcome of a recent assessment about a person's behaviours was discussed and a decision taken to progress some individual work was made. We raised concerns about the outcome of the psychologist's assessment and the possible impact of a film the person had chosen to see. The member of the MDT meeting told us the person enjoyed 'popular culture' and they would link their work to the person's activities.

We saw people had involvement from a range of other services including community nurses, speech and language therapists, GPs, police community liaison offices. This meant the service worked with other professionals to support people. We saw other professionals had attended meetings and contributed to people's development.

The registered provider had in place a pain measurement tool to support staff to assess people's pain levels who were unable to verbally communicate. We saw the tool had been used with one person and pain relief had been administered.

People said they told staff if they weren't well and the staff either made an appointment at the doctors or the doctor would come out to them. Two of the people we spoke with had appointments one for the dentist and one for the doctors. They both knew about them and knew what was going to happen. This meant people's appointments had been arranged and people were informed of the arrangements.

We found staff had tried to care for one person with high sensory needs. We saw a bedroom had been given over to the person and had been adapted. The person was able to use this room to engage in activities which included using for example different textured materials they could cover on the walls. This meant the registered provider had creatively adapted a separate space to meet a person's needs.

Staff confirmed to us they had undergone an induction period. One staff member who had recently started working at Huntercombe House told us about their induction training and said they had shadowed another worker until they "felt confident to work on their own."

We found the acting manager had put into place a new training scheme including roles and responsibilities, boundaries, moving and handling and autism. We saw that staff were allocated training days on the rota which showed specific time had been set aside to ensure staff were trained.

Requires Improvement

# Is the service effective?

We looked at the supervision records for five staff. Supervision is a meeting between a staff member and their line manager to discuss their performance, training needs and any personal issues which may affect their work. One staff member said, “It gives them a chance to tell you if anything is wrong or what you are doing right.” We found staff were expected to have supervision four times per year. Not all of the records we looked at indicated staff had regularly received supervision. For example, we saw one person received supervision in January, February and July in 2014 whilst another person had one supervision meeting in February 2014 with no further meetings in 2014. The acting manager showed us a new supervision contract they had implemented which established an agreement between each member of staff and their manager. We saw supervision agreements which had been signed by staff in June and July this year contained agreements about frequency and content of supervision. This meant the foundations had been put in place to improve the frequency and content of supervision meetings.

Staff told us about training they had received relevant to their role. One person told us they received, “Loads of training”, they told us this included moving and handling and specific training for the client group.” Another person told us they had received training in “health and safety, first aid and food hygiene.” Staff told us they would go to managers if they needed support.

We looked at the records appertaining to people’s weights and found the service did not regularly weigh people. Records found in the home indicated people had lost weight. We discussed weight loss with the acting manager. They told us one person had been attending a slimming class and accounted for their weight loss. We saw in their file records of the their weight loss from their slimming class, their file also said, ‘Please document (person’s) weight after they attended (the slimming class)’ and found no weights had been documented. The acting manager told us staff had worked to improve another person’s diet on advice from their GP and they had lost weight which had improved their health outcomes.

We expressed concern to the acting manager about those people who were unable to verbally communicate about the effectiveness of their diet and the measures which needed to be in place to ensure they are not losing unnecessary weight. We looked at the fluid and food intake for one such person and found over a period of a week it was recorded they had been asleep at breakfast time and no food or fluid had been recorded when they had woken up. The acting manager told us they had experienced difficulty in finding a way to measure the person’s weights but this had now been sourced. We asked the acting manager to send us the person’s weights by email. The emailed information showed the person had not been weighed on a regular basis; however the person’s weight had remained stable. This meant that although arrangements had not been in place to check on a person’s weight their diet had been effective.

We saw in addition to the main laundry there were two other small utility rooms. The acting manager explained to us that these were areas which people used to do their own washing. We found the washing in the machine belonged to a person who had put it in the machine the previous day. The person who was due to use the washing machine that morning was not able to do so. We saw in people’s bedrooms a timetable for everyone to do their washing. The timetables together with activity sheets and lists of cleaning tasks were on torn pieces of paper stuck to people’s bathroom doors with sticky tape. One person was able to tell us using the charts when they did their washing, another person was confused about their activities and when they began and ended, another person could not tell us when they did their washing. We found these charts were insufficiently personalised to give people a structure to their day.

We noted in the minutes of the MDT meetings records decisions had been made to change people’s care plans. In the information provided to the CQC prior to the inspection we were told, 'The support plans are prepared by the Multi-Disciplinary Team and where possible, the individual themselves'.

We found the acting manager and the MDT had put into place a range of initiatives to address the shortfalls they had identified in the effectiveness of the service. As some of this work had recently commenced it was therefore difficult to assess the impact, however they included increased training and using staff skills and talents in the service to engage people in different activities.

Good

# Is the service caring?

## Our findings

One person told us they enjoyed living at Huntercombe House. One relative told us they found the staff, "Extremely helpful and caring." They told us how their relative often preferred "older staff" who had worked at Huntercombe House for a while. They told us the staff took their relative to see a previous carer at their bungalow which they enjoyed. Another relative told us they had, "No complaints" about the care given at Huntercombe House.

We reviewed five people's records which all included information about each person's preferences. Staff were able to tell us about each person's likes and dislikes and their preferred routines. They also told us about the specific behaviours of people they cared for and what they meant. We observed people were relaxed in the care of staff.

We observed staff interacting with people and this was carried out in a caring way, their conversation was supportive and staff explained to people what was happening. We observed a group getting ready to go out. The staff engaged people in conversation, listened to what they were saying and did not interrupt them. When people spoke to us their carers stood at a respectful distance and only interjected if people struggled to communicate their meaning to us. We observed that when people turned to the carers for support the carers were able to anticipate people's needs and guided them with words to use.

When we looked in people's rooms we saw they had been personalised with pictures, ornaments and furnishings. We looked at two rooms where people were staying on respite or short term basis at Huntercombe House at the time of our inspection. These rooms were not personalised in the same way as those living at Huntercombe House on a more permanent basis. In one of the rooms we found a copy of the Bristol Stool Chart designed to classify human faeces was stuck to the en-suite bathroom wall. We found this detracted from the care environment. When we pointed this out to the acting manager they were unable to offer us an explanation or the purpose of having the chart in an ensuite bathroom.

Staff we spoke with were able to tell us about people's care needs and the support they provided to people. One person told us they were being taken out for new trainers and showed us their new footwear on the second day of our inspection. They told us they had enjoyed their time out shopping.

We looked at the arrangements in place to support people to make difficult decisions where they may not have had anybody to represent them. We saw that one person had an advocate whom they could contact or ask the staff to contact on their behalf. We also spoke to one relative who had an advocate whom the service involved in meetings. This meant people were supported by others who were independent to the service.

We observed a lunchtime taking place. We saw staff wait until a person had placed an item in their room and locked the door. The staff did not rush the person into the dining room. We saw staff and people who used the service enter the dining room together. Staff sat down at the tables as people went to the kitchen hatch to collect their meal. People ate their meals independently. Once sat at the table we saw staff lean back on their chairs, some were sat not facing the table whilst people ate their meals. We did not observe staff using mealtimes to engage people in positive interaction. We spoke to the acting manager about this who told us staff did not always want to eat with people but preferred to eat during their own breaks in a twelve hour shift. However the acting manager agreed people's experience of mealtimes required improvement.

Good

# Is the service responsive?

## Our findings

We spoke to one person who told us about their chairing role in the house meetings which are held fortnightly on a Monday. They told us they talked about, "Stuff in the house that needs repairing, what is happening in the house, sorting trips out and activities." When we asked if the staff did what they asked for, they said, "Yes they had got two new buses, the sensory garden, decorating and new furniture." The person told us they arranged more days out so that "different ones suit different clients and they take it in turns to get their choice." The person said they had been to Seahouses, Seaton Carew, Beamish, bowling and they went to the Sunderland air show. People told us with a sense of pride about their house meetings and what they had achieved.

One person said they were very fond of the sensory garden and together with another person and had, "Done it up together". We found the service was effective in engaging people to influence their environment and activities.

We found information on people's files provided by other agencies which informed the staff about people's background. The acting manager told us they gathered information about people prior to admission to see if they could meet the person's care needs. We also found information provided by people's families and where concerns about behaviour that challenged the service and others had been raised these had been acted upon including conducting further assessments. In one person's files it was recorded, 'Family will be approached when plan is in place'. This meant the service took family concerns seriously and addressed them as required.

During our inspections we saw staff quickly responded to people's needs and behaviours that challenged the service to reduce adverse outcomes. For example, we saw a person move quickly along a corridor and their supervising staff followed quickly along behind to check they were safe. The staff told us they needed to avoid the risks associated with the person's need for sensory stimulation by grabbing potentially hot drinks and pouring them over their head. The staff discussed with us the risks of the person also wanting to continually drink fluids and how this was managed.

Staff were aware of the triggers to people which caused them to exhibit behaviour that challenged the service. They told us how they diverted people's attention and how people responded to them. We saw the care plans documented the least restrictive practices. Staff told us they did not restrain people and were taught to use all other diversion methods. One member of staff told us, "Restraining people is the very last thing we do."

Staff told us about the relatives who had visited and how people had maintained contact with their families. We saw a contacts chart had been drawn up so staff were aware of who had contact arranged with their family each day. We found contacts were referred to in the daily notes. One relative who lived some distance away told us they were very satisfied with the contact arrangements in place and the way the staff responded to them when they visited.

We also found records of meetings with family members, for example a meeting was held to attempt to address issues raised by a family member. The staff team at Huntercombe House invited the family in to discuss the issues and try and resolve them. This meant the service had responded to concerns and sought a way forward between the family and the staff.

We looked at the complaints procedure and the complaints made since our last inspection. We saw three complaints had been made since January 2014. On each occasion the acting manager had provided a response, and the responses included explanations and apologies. On one occasion the acting manager had given the family different options and invited them to suggest a solution. The relatives of the people we spoke to by telephone said they did not have any recent complaints. Two relatives told us they had raised concerns over a year ago and these had been quickly dealt with. One relative expressed dissatisfaction to us about the service and the acting manager explained they were trying to engage the family in a different way by holding meetings with them. We saw one of these meetings took place during our inspection. The acting manager's response to complaints meant people could be confident their complaints would be addressed.

We saw keyworker meetings were in place and took place every four weeks. Each person's progress was reviewed and actions were agreed for the next four weeks. One person told us they could attend their reviews but preferred not to so they waited for their keyworker to tell them about what was discussed. We found actions had been agreed to support each person including for example a meeting to be set up with the family to discuss his progress and the

Good

# Is the service responsive?

'importance of keeping visits structured' and progress had been made towards completing the actions. In one person's keyworker meetings we saw actions had been recorded against themes which included activities, family contact, environment, eating out and flexible activity time.

Goals had been reviewed and additional goals were planned if the person made progress. This meant that the service responded to people's changing needs and ensured everyone involved was working together.

Requires Improvement

# Is the service well-led?

## Our findings

We found the registered manager had not been managing the service for a number of months prior to our inspection. The deputy manager had been appointed as the acting manager and we spoke with them about the need to have a registered manager in post.

The registered provider told us in their pre-inspection information a steering group had been developed which had led to a development plan. The steering group had staff members from different backgrounds to contribute to the development of the home. We saw Huntercombe House had a development plan in place dated 28 May 2014 and the plan had been reviewed. The plan included developing a consistent process for recruitment, training for staff, meetings for families, rota management and addressing the issue of staff burnout. We also saw the plan included progress on the development of a service model in line with good practice and progress had been made towards this e.g. meetings were held about individual people to which everyone involved with them was invited to take a holistic view of the person. The plan also included the acting manager undertaking informal training sessions with staff on 'Getting to Know You'. We saw dates had been agreed for the training. The acting manager explained to us these training sessions were about sharing best practice with the staff by ensuring people's wants wishes and needs are respected during support sessions. This meant the registered provider had in place a plan to develop and improve the service delivery.

We were told by the acting manager the service was a psychological led service through a multi-disciplinary team (MDT). The MDT consisted of a consultant clinical psychologist, an assistant psychologist, an occupational therapist, the acting manager and care team members. We saw regular MDT meetings had been held. When we spoke to the MDT members they told us they recognised the model they were working to required further development. They explained to us not everyone was discussed at every weekly meeting and they had a rota in place. We asked the MDT members about how the decisions of the MDT meeting were conveyed to the staff. They told us the acting manager attended together with senior staff and they held separate meetings about people and invited staff in to discuss issues. We saw the minutes of the MDT meetings were available to staff and there were separate meetings on each person in place. This meant the acting manager had systems in place to regularly monitor and review people's care.

We also spoke to the acting manager who described to us the process of cultural change the service was undergoing to meet the needs of the people who lived there. This included the use of a multi-disciplinary team (MDT) working together with care staff to drive up performance in the care given to people who lived in Huntercombe House. The acting manager told us of their wish to engage the care staff further in the service and increasingly use their expertise and interests to support people in different ways. We saw on the staff notice board the manager was looking for volunteers to carry projects forward.

We found the acting manager and the MDT had put into place a range of initiatives to ensure the service was well led. The acting manager and MDT members were able to explain to us the rationale behind each initiative. We found the service had begun to make the necessary changes but further time was required to sustain those changes for the service to achieve a rating of 'good'.

We found the service had commissioned an independent advocacy service to carry out a survey to seek feedback from family members. At the time of inspection this was in the process of being sent out. The service had also developed an easy to read version so that the people who lived at Huntercombe House could give their views.

The acting manager told us about two areas of improvement recent surveys had identified, these were involvement in support planning and involvement with interviews. The acting manager demonstrated the thinking which had been developed to improve these areas. This meant people's views had been taken seriously and were being responded to.

We looked to see if any audits were carried out in the home. We saw random checks were in place to monitor medication administration which had been taken home by people. We also saw random checks were in place for people's personal money to ensure people's finances were accounted for.

Requires Improvement

# Is the service well-led?

The acting manager told us they had changed the cleaning hours earlier in the year to make sure Huntercombe House was cleaned at weekends. We found since the changes had been made no cleanliness and infection control auditing had been carried out.

Accidents and incident reports were recorded and audited by the acting manager. The acting manager explained they looked at accident trends to see if action was required to reduce any risks to people who lived in the home. We saw the accidents records in one file and the acting manager told us how they were collated. We saw information on accidents and incidents were reviewed in people's care planning meetings and risk management discussions took place.

We looked at the staff room notice board and found the management had responded to concerns raised and give clear guidance to staff about the required level of behaviour. We saw two memos to staff about messages on Facebook and sleeping on duty were displayed on the notice board. This meant the acting manager was listening to staff and providing guidance on their expected behaviour.

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 did not take formal enforcement action at this stage. 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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br><br>The provider did not have in place effective operating systems to assess, prevent, detect and control the spread of infections. . Regulation 12 (2) (a). |