

Ordinary Life Project Association(The) Ordinary Life Project Association - 67a St George's Road

Inspection report

67a St George's Road
Semington
Wiltshire
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Tel: 01380870168

Date of inspection visit:
27 September 2017

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01 November 2017

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

At the last inspection on 27 July and 3 August 2016, we found breaches of legal requirements. We asked the provider to take action to make improvements on developing person centred care plans and to assess people's mental capacity to make complex decisions. After the comprehensive inspection, the provider wrote to us to say the action they would take to meet legal requirements in relation to Regulations 9 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements were made.

67a St George's Road is registered to provide accommodation and personal care for up to three people with learning disabilities. At the time of the inspection three people were living at the service.

This inspection was unannounced and took place on 27 September 2017

A registered manager was 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.

Quality assurance systems were in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people. Monthly self-assessments audits were undertaken by the registered manager which senior manager's reviewed. However, the internal self- assessment was not consistent with the findings of this inspection. For example, findings from the care planning and medicine self-assessments had not identified any shortfalls.

Some people were prescribed with when required medicines (PRN) for pain relief including topical creams and to reduce agitation. Medicine procedures gave staff direction to develop protocols on the administration of PRN medicines. However, protocols were not always in place for medicines to be administered when required. This meant staff were making decisions on when to administer PRN medicines instead of having clear guidance on administering PRN medicines consistently.

Where people used non-verbal language to communicate, a pain assessment tools was used by staff to assess the person's level of pain. The pain scale ensured staff were able to identify the level of pain the person was experiencing and take appropriate action. For example, administer pain relief.

People were able to follow their own preferred routines during the day. Care plans were variable and some were more people centred than others. Although the care plans had been reviewed, the dates and the progress made were not included. Staff said the quality of the care plans had improved. One person told us where their care plan was kept and told us staff had read their care plan to them.

One person told us they felt safe living at the service. Other people living at the service were not able to tell

us what feeling safe meant to them. The staff we spoke with said they had attended safeguarding of abuse training. They knew how to identify the signs of abuse and were knowledgeable about the procedures for reporting their concerns.

We saw good interactions between people and staff. We saw staff use humour with one person and a gentle approach to help another person who became distressed. Arrangements were in place for people to have in-house activities, one to one outings and trips in the local community

Staff were aware of the individual's risks which included supporting people with mobility needs and for people at risk of choking. Intervention charts were completed for repositioning, food and fluid intake and for weight monitoring. This meant preventative measures were taken to ensure risks were minimised.

Staff were supported to develop their skills and to meet the responsibilities of their role. One to one supervision was with the registered manager. Staff said during their one to ones they discussed their concerns, the people at the service and performance.

When people had accidents, incidents or near misses the staff recorded the events.. The registered manager reviewed the reports to ensure all appropriate action was taken.

Staff told us and duty rotas confirmed two staff were on duty during the day and at night one staff was awake in the premises. We saw staff were available and there was time for activities.

One person told us they made all their day to day decisions. Staff knew the day to day decisions people were able to make. We saw people's capacity to make decisions about their care and treatment was assessed. Where people lacked capacity best interest decisions were taken with the involvement of the person, appropriate professionals, staff and relatives. We saw best interest decisions included applications for Deprivation of Liberty Safeguards (DoLS) for continuous supervisions.

The people at the service had support with their healthcare needs. People were registered with a GP and they had an annual health checks.

The complaints procedure was kept in people's files. A flow chart format was used to detail the procedure for making complaints." The registered manager told us there were no complaints received since the last inspection.

Staff said since the last inspection there had been improvements. A member of staff said information was more accessible. They said the registered manager was approachable and the team worked well together.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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 consistently safe.

Medicines were not always managed safely. Procedures were not developed on the administration of when required medicines (PRN).

Risks identified were assessed and action plans were developed on minimising the risk. Member of staff were knowledgeable on actions necessary to reduce risks.

There were sufficient staff to support people and we observed that staff were visible and available to people.

We saw people seek the attention of the staff for company and for support and assistance. Staff knew the types of abuse and the responsibilities placed on them to report abuse.

Is the service effective?

Good 

The service effective.

Staff enabled people to make choices and told us how people made them aware of their decisions. People's mental capacity to make complex decisions were assessed and best interest decisions were taken where they people lacked mental capacity.

Staff had the knowledge and skills needed to carry out their roles. There were arrangements in place to support staff to meet the responsibilities of their role. Staff attended training set by the provider as mandatory and had opportunities for personal development through one to one supervision with the registered manager.

People's dietary requirements were catered for.

Is the service caring?

Good 

The service was caring

People were treated with kindness. We saw positive interactions

between staff and people using the service. Staff knew people's needs well and there was a calm and friendly atmosphere.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Good ●

The service was responsive

Although care plans were reviewed the quality were variable on people's preferences. Care plans were not dated and the progress made on the action plans were recorded.

One person told us the staff read their care plan to them. People were alert and connected with the events of the day.

There were no complaints received at the service since our last inspection.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Quality assurance systems were in place but the in-house assessments did not fully correspond with the finding of this inspection.

Staff said the team worked well together and the registered manager was approachable. They said morale had improved.

Ordinary Life Project Association - 67a St George's Road

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 27 September 2017 and was unannounced.

Before the inspection, we 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 reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector. We spoke with one person and observed the interaction two people who were unable to verbally communicate had with staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We wrote to social and health care professional and relatives asking for their feedback about the service. We received feedback from one social care professional and from one family. We spoke with the two staff, the registered manager, area manager and training manager.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included three care and support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and

observed care practices for part of the day.

Is the service safe?

Our findings

Medicines were not always managed safely. Some people were prescribed with medicines to be administered as required (PRN) for minor ailments, for pain relief and for anxiety. PRN protocols were not in place for some topical creams and for medicines prescribed to reduce anxiety. The Ordinary Life Project Association (OLPA) medicine procedure states "the person's care notes should give detailed information about what the medicines are for, the maximum amount to be given and the intervals between each medicine". Staff were not given details about what the medicine were for, the symptoms to look out for and when to offer the medicine. This meant staff were not following the provider's procedures.

During the inspection we saw one person was becoming agitated. Documentation, we saw, gave staff guidance to offer PRN medicines when their behaviours escalated. For example, the positive behaviour plan for one person gave staff direction to offer PRN medicines if their anxiety levels escalated. Their medication administration record (MAR) also stated PRN medicines were to be administered for extreme anxiety. However, procedure for administering PRN medicine for agitation was not in place. A member of staff told us the previous day PRN medicines were administered. When we asked why PRN medicines were not offered on this occasion the staff said the level of anxiety was not as acute as observed the day before. They explained there was some reluctance to administer this medicine because the person became drowsy the following day. Another member of staff said this issue was discussed with the registered manager and a medicine review by the GP was to be requested. This meant there was no clear guidance in place to support staff in the administration of people's PRN medicines.

Although records showed PRN medicines were administered protocols for some prescribed creams were not in place. This meant staff were not given details on the frequency of use, the thickness of application and areas of the body to which the cream was to be applied.

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

Where people who were unable to verbally communicate had been prescribed PRN medicines for pain relief, staff had used an assessment tool to help identify distress signs in people. The assessment tool assisted staff to identify signs and behaviours which indicate they were experiencing pain. This meant staff were able to identify signs of distress for when it was appropriate to administer PRN pain relief medicines.

We viewed epilepsy profiles for two people controlled with medicines. For one person the action plan was for staff to maintain records of seizures and to contact emergency services as the person had not experienced a seizure in five years .

Staff said they had received competency based medicine training and the training matrix confirmed all staff had attended "Medicines and Safe Handling Awareness" training. Medicine care plans detailed people's preferred method of taking their medicines.

People's MAR file included information leaflets which gave staff information on the purpose of their prescribed medicines and their side effects. Staff administered medicines and people's mental capacity assessments to make decisions about their medicines were kept in the MAR file. Mental capacity assessments showed people lacked capacity to self administer their medicines.

Staff signed the MAR charts to show they had administered the medicines at the prescribed times. The MAR charts we saw were correctly signed and corresponded with the medicines administered. The staff we spoke with said two staff signed the MAR charts to promote safe administration of medicines. They said one member of staff administered the medicine while the other witnessed the medicine being administered.

One person told us they felt safe living at the home. The other people living at the home were not able to tell us what feeling safe meant to them. We saw people seek the company and assistance of staff to undertake activities. The family members of one person said their relative was safe at the home. They told us "we have never experienced a problem nor felt there could be a problem." Staff said they attended training on how to protect people from avoidable abuse. The training matrix in place confirmed staff that attended this training. Staff knew the types of abuse and the actions they must take for suspected abuse. A member of staff said it was important that staff follow the procedures when reporting allegations of abuse to ensure all staff were aware of the actions already taken.

People's risks were identified and action plans were developed on how to manage their risks. Staff said there were procedures on risk management. They told us there were people at risk of choking, with mobility needs and some people had experienced epileptic seizures. These staff also told us that guidance from specialists was provided on how to use equipment such as overhead tracking systems and how to assist people with eating and drinking.

Intervention charts on the preventative action to be followed by the staff were in place for people identified at risk of pressure sore, choking and malnutrition. Monitoring charts were in place for repositioning, food and fluid intake and weight monitoring. The records were fully completed by the staff to show they had followed the action plans.

One person told us the staff made them feel safe during transfers. Occupational Therapists (OT) support plans were in place which provided staff with guidance on safe moving and handling techniques. OT support plans included photographs on how staff were to support the person using equipment and aids. For one person, the OT support plan was accompanied by a moving and handling risk assessment which detailed the equipment for each transfer and the level of support needed from the staff. The staff told us they had attended moving and handling training and the training matrix confirmed all staff had attended this training. They told us the registered manager had attended the moving and handling training programme which meant they had additional support for safe moving and handling techniques if required.

The epilepsy risk assessment for one person detailed the most recent seizure which occurred in 2012 and listed the medicines prescribed to control the person's seizures. The action plans stated that staff must be trained and records confirmed staff had attended training. Monitors were to be used at night to alert staff the person was having a seizure.

Accidents and incidents involving people were documented. Staff said they reported accidents and incidents. They said body maps were used to illustrate the location of injuries in the body.

There were sufficient numbers of staff on duty to meet the needs of people. Staff said there were two staff on duty at all times during the day and at night one member of staff was awake in the premises. The rota we saw confirmed the statements of the staff. We observed that staff were visible and available to people.

Is the service effective?

Our findings

At the previous inspection we found a breach of Regulation 11 Health and Social Care Act Regulated Activities Regulations 2014. We found that people's mental capacity to make specific decisions had not been assessed. Staff gained consent from relatives without legal powers to make care and treatment decisions. The legal framework for depriving people of their liberty was not in place. This included the use of bed rails and covert medicines. We found improvements had taken place.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff we spoke with were knowledgeable about the principles of the MCA. They told us the day to day decisions people were able to make. The "traffic light consent and capacity" care plan listed the decisions people were able to make along with the support needed from the staff to enable decision making. For one person the care plan stated the person was able to consent to eating and drinking decisions as well as activities. The staff had to support the person with making decisions about nutritious foods.

One person told us they made all their day to day decisions and their care plan stated they were able to make all decisions including decisions about their personal care, medicines and meals. The family members of one person told us they were involved with "decision making on all key issues and the staff are aware that they need to contact the family in advance to talk about issues, plans etc. In addition, XX (brother) has oversight and control of XX financial affairs."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

Deprivation of liberty authorisations had been sought for three people. We saw that people's mental capacity to make decisions about their care and treatment was assessed. Where people were identified as lacking mental capacity, best interest decisions were made on their behalf. Best interest decisions were reached with the involvement of the relevant professionals and registered manager which included DoLS applications for continuous supervision.

Positive behaviour management plans were in place on how staff were to manage difficult behaviours of concern. For one person the staff had gained specialist support from a community behaviour nurse on how to manage difficult behaviours consistently. The action plan detailed how staff were to avoid difficult behaviours by using humour and a calm tone for example. Also included were the signs that indicated the

person had become anxious and how staff were to respond to these triggers. For example, staff were to use distraction techniques or offer medicines to reduce anxiety.

Care plans on managing verbal and physical aggression were in place. The action plans provided clear guidance to staff and ensured there was a consistent approach when managing difficult behaviours. We saw the staff were to give one person "time" to accept personal care and where there were repeated calls for help the same staff were to respond. Antecedents behaviour and consequence (ABC) charts were used to record behaviours that staff found difficult to manage. The ABC records for August 2016 showed this person had become physically aggressive during personal care. The staff had recorded the "tasks were stopped and waited for the situation to become calm". This meant staff were following guidance on how to manage behaviours for people who resisted personal care.

Systems were in place to ensure staff had the skills needed to meet the responsibilities of their roles. The training matrix provided showed staff had attended mandatory training set by the provider. The training manager told us the training provided met the Skills for Care guidelines for staff working in specific care environments. For example, moving and handling and positive behaviour management. Staff spoke positively about the quality and quantity of training they had access to. They told us there were opportunities to gain vocational qualifications. We saw staff had undertaken vocational related qualifications in Understanding Nutrition for people with learning disabilities. The registered manager told us they were to undertake vocational related qualification in improving leadership skills.

The family members of one person told us "we are not aware of the qualifications of the OLPA team that look after our sister but the care and attention they display and the discipline of learning about our sister's needs and requirements have been very good." New staff had an induction when they started work at the service. The staff we spoke with said there was an in-house induction with the registered manager.

One to one supervision was with the registered manager. A member of staff said "there is plenty [registered manager] ensures staff have a one to one." Staff said at their one to one supervision they discussed issues of concerns, the people living at the service, their performance and they were asked for suggestions on improving the service.

People's dietary requirements were catered for at the home. One person said they liked the meals and we observed staff supporting people to eat their meals during the lunch and tea time meals. A member of staff told us specific menus were not devised, instead people were asked before mealtimes for their suggestions and preferences. Staff said meals were freshly prepared daily by them.

Arrangements were in place for people to access dietary and nutritional specialists which helped to meet their assessed needs. People at the service were served with textured diets because of their medical condition. Speech and Language therapists (SaLT) were involved and had provided staff with guidance on how to prepare meals, the foods that were safe to eat and those to be avoided. Also included was the position people must be sitting to eat their meals safely. We saw the guidance on textured diets were kept in people's care files and in the kitchen to ensure the meals served met people's needs. Eating and drinking care plans included the support people needed from the staff to eat their meals, the adapted cutlery and utensils needed and the frequency drinks must be provided. For one person's fluids were thickened and the directions for the thickeners were indicated in their care plan. Visual eating and drinking care plans kept in the kitchen and gave staff additional guidance to have a calm environment during mealtimes, listed the support people needed from staff and key signs of choking.

People were supported with ongoing healthcare. The family members of one person told us they were kept

informed about healthcare visits. They said "the home is also responsive to when we, the family, say that a GP visit is necessary." Staff told us there were good working partnerships with the GP. They said GP visits to the home were arranged for two people and one person was supported to visit the GP practice. These staff also said there was involvement from specialist such as occupational therapists, speech and language therapists and physiotherapists. Records of visit from healthcare professionals supported staffs comments about people having access to GP's and community healthcare specialists. We saw details of visits were recorded and included were the purpose and outcome of visits.

Hospital passports were developed to give medical staff helpful information about the person and their health in the event of a hospital admission. Recorded were the person's details that medical staff must know, other important information and their likes and dislikes.

Is the service caring?

Our findings

At the previous inspection we found a breach of Regulation 9 Person centred care of the Health and Social Care Act Regulated Activities Regulations 2014. We found that care plans were not person centred and were not updated to include the advice from healthcare professionals. We found improvements had taken place.

People received care that was responsive to their needs. One person told us where their care plans were kept and confirmed staff had read their care plans to them. The family members of one person told us they were invited to review meetings and their suggestions were taken seriously and acted upon. Staff said care plans were in order and the content had improved.

People's needs were assessed and social workers provided comprehensive assessments before the admission. We saw care managers had reviewed the comprehensive assessments in 2016 with the person and where appropriate with their relatives and staff at the home. Actions identified through the review meeting were acted upon by the registered manager. For example, person the registered manager had updated the care plan for one person and had added photographs to ensure staff were able to identify the appropriate aids and when they were to be used.

Care plans were developed on how staff were to meet people's needs and some included their likes, dislikes and preferences. Care plans were not always dated and the progress made was not always recorded. The morning routine care plan for one person was not as person centred as the evening routine. For example the morning routine had guideline on how staff were to meet the person needs while the evening routine care plan included the person preferences such as having their side lamp and music. This meant care plans were person centred but variable.

One person told us the staff made sure they looked "the way they liked". For example, their hair was always "blow dried". Their routine care plans detailed the aspects of care they were able to manage for themselves and their preferences on how the staff were to assist them with personal care. Personal care plans for another person also included aspects of care people they were able to manage for themselves and for staff to support the person with making choices. For example, the dressing care plan instructed staff to give two visual choices for the person to make decisions about the clothes and the hair care plan said the person "liked having their hair washed daily."

Personal profiles included information about the person's qualities and personal characteristics, for example one person was described as "sociable". Their relationships with family and their ability to communicate were also included. Communication care plans were devised and detailed how people expressed their wishes. For one person the communication care plan stated the person used single words such as "yes or no" to communicate verbally. For another person the care plan included staff's interpretation of specific words used by the person.

People were supported to maintain relationships with those that mattered to them. One person told us they had regular visits from family members. The family members of one person told us "we are not there 24x7

and can only judge but what we see. However, we do know XX and when we see her we are very aware when she is happy/unhappy, disturbed/contented etc. If we ever feel that XX is not her usual self (which is fairly quiet and contented) then we discuss this with the carers."

The care plan for one person on maintaining relationships gave staff guidance on the preferred areas for visits to take place, such as bedrooms for privacy and the actions to be taken if visits were to be cancelled. Detailed were the names of the family members and how the person relied on them for support. Important dates were listed to ensure the person received support from staff to remember dates of celebrations and birthday.

People were supported to take part in social activities. The family members of one person told us "more can always be done and we are in discussion with the home and the carers to express views about areas for improvement for XX wellbeing." Staff told us the arrangements in place to ensure people had opportunities to participate in-house activities and outings. There was an activity rota in place and arrangements were in place for daily one to one in-house activities, twice weekly trips in the local community and weekly outings. During the inspection we observed staff playing games with one person while another person spent time with a member of staff going through their scrap book.

Staff said there was a verbal handover about people's current needs when they arrived on duty. They said information about people's wellbeing, care and treatment was recorded. We saw individual diaries were used by the staff to record routines followed, appointments and activities.

One person told us they would tell the staff their complaints. A copy of the complaints procedure was kept in people's files. The complaints flow chart sets the procedure in an easy to follow format which included the contact details of the staff that will investigate their concerns. Also included were the steps to be followed where the outcome of the complaint was not satisfactory. The registered manager told there had not been any complaints from relatives or people since the last inspection.

Is the service responsive?

Our findings

At the previous inspection we found a breach of Regulation 9 Person centred care of the Health and Social Care Act Regulated Activities Regulations 2014. We found that care plans were not person centred and were not updated to include the advice from healthcare professionals. We found improvements had taken place. We observed the staff were following all guidance written by professionals e.g. moving and handling plans, Speech and Language Therapists (SALT) assessments.

People received care that was responsive to their needs. One person told us where their care plans were kept and confirmed staff had read their care plans to them. The family members of one person told us they were invited to review meetings and their suggestions were taken seriously and acted upon. Staff said care plans were in order and the content had improved.

People's needs were assessed and social workers provided comprehensive assessments before the admission. We saw care managers had reviewed the comprehensive assessments in 2016 with the person and where appropriate with their relatives and staff at the home. Actions identified through the review meeting were acted upon by the registered manager. For example, person the registered manager had updated the care plan for one person and had added photographs to ensure staff were able to identify the appropriate aids and when they were to be used.

Care plans were developed on how staff were to meet people's needs and some included their likes, dislikes and preferences. Care plans were not always dated and the progress made was not always recorded. The morning routine care plan for one person was not as person centred as the evening routine. For example the morning routine had guideline on how staff were to meet the person needs while the evening routine care plan included the person preferences such as having their side lamp and music. The registered manager told us the care plans were to be further developed to include people's preferences. This meant care plans were person centred but variable.

One person told us the staff made sure they looked "the way they liked". For example, their hair was always "blow dried". Their routine care plans detailed the aspects of care they were able to manage for themselves and their preferences on how the staff were to assist them with personal care. Personal care plans for another person also included aspects of care people they were able to manage for themselves and for staff to support the person with making choices. For example, the dressing care plan instructed staff to give two visual choices for the person to make decisions about the clothes and the hair care plan said the person "liked having their hair washed daily."

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Is the service well-led?

Our findings

Audits were used to measure and review the delivery of care. The registered manager carried out self-assessments that focussed on care delivery, health and safety, policies and procedures and staffing. The registered manager told us the self-assessments were reviewed monthly and updated on the actions taken. The completed self-assessment was then assessed by senior managers at their monthly meetings. However the self-assessment systems had not always been effective in identifying the shortfalls in the service. We discussed with the registered manager the inconsistencies between the self-assessment and the inspection findings. For example, care planning and medicine systems. While audits of medicines were monthly for stocks held and medicines received, the audit did not cover procedures such as the monitoring of 'when required' medicines. We were reassured by the registered manager that they would take immediate action to update the care plans and procedures for 'when required' medicines.

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

We saw health and safety audits were based on the environment. Where faults and repairs were identified action plans were developed and included the names of staff responsible for completing the tasks and the date of completion. Actions not met were carried forward to the next audit. Environmental checks by contractors were for fire alarm systems, equipment such as hoists, heating systems and portable appliance equipment.

A registered manager was in post. The registered manager told us their management style was to lead by example as well as open to suggestions, fair, honest and approachable. They said there was learning from incidents. Staff said they felt well supported by the registered manager. A member of staff said "we get on well together and we let each other know what is going on."

The registered manager was aware of the key challenges which included developing the staff team as new staff were recruited for vacancies. They said the "staff care for the people they support. It's an inclusive team. For example, the night staff attend team meetings and are part of the team."

The organisation aims to enable people with a learning disability to maintain and enjoy quality lifestyles within ordinary communities. There was open communication with people who use the service, those that matter to them and staff. The family members of one person told us their views about the service were gained. Questionnaires were available at the service for visitors to give their feedback about the service. The registered manager said feedback was reviewed individually as it was received, suggestions for improvements were acted upon but mostly feedback was complimentary. A social health care professional gave us feedback about their previous visits which had occurred six months previously. We saw from the action plan provided that the registered manager had taken action on the recommendations made.

Team meetings were monthly and the minutes of the meetings were recorded. We were present for part of a

combined team and training meeting on food safety. At the team meeting the minutes of the previous meeting was discussed as well as a review of the action plan. Actions were closed where they were met and where there were outstanding actions these were carried forward to the next meeting.

Staff reported incidents and accidents which the registered manager analysed to ensure appropriate action was taken by staff following the event. The registered manager said the reports were then sent to head office where the reports were analysed at provider level by senior managers for patterns and trends.

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 17 HSCA RA Regulations 2014 Good governance Audits in place had not identified that procedures were not in place for medicines prescribed to be taken or applied as required.