

Creative Support Limited

Creative Support - Warwickshire Supported Living Service

Inspection report

Napton House
1-3 Wharf Street
Warwick
Warwickshire
CV34 4NX

Tel: 01926401865
Website: www.creativesupport.co.uk

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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?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

An unannounced inspection visit took place on 27 June 2018.

This was the first inspection of this service following its registration with us in July 2017.

Creative Support – Napton House is registered to provide personal care to adults with learning disabilities, autism or autistic spectrum disorders. Care and support was provided to people at prearranged times in a specialist 'extra care' housing service so each person had their own flat.

Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. Each person has their own individual tenancy agreement and is the occupant's own home and Creative Support provides their care package. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection only looked at people's personal care service.

Napton House has 15 individual flats. People living at Napton House share on site facilities such as a lift, lounge, kitchen, laundry, garden and an activities area.

At the time of this inspection visit, staff supported 15 people in 15 apartments, however the provider told us only six people received personal care. Therefore, for this inspection, we only looked at the care and support for those people receiving personal care.

The service did not have a registered manager. 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.' A manager had been appointed and was in the process of registering with us.

Overall, people were pleased and satisfied with the quality of care provided although for some people, inconsistency of staff and management had affected the quality of care they received. People were supported to remain as independent as possible so they could live their lives as they wanted. People made choices about what they wanted to do for themselves, such as what to do, where to go and what to wear. However, where people lacked understanding to make some decisions, there was limited information to demonstrate decisions were made in people's best interests. People were encouraged to maintain important relationships with family and people built friendships with others living at Napton House.

Care plans contained information for staff to help them to provide the individual care people required. For people assessed as being at risk, care records included information so staff knew how to minimise risks. However, information to manage specific risks and behaviours that could become challenging, were not completed or followed which meant there was an inconsistent approach in how staff supported those

individuals.

Staff knew how to keep people safe from the risk of abuse. Staff and management understood what actions they needed to take if they had any concerns for people's wellbeing or safety.

Staffing levels had recently improved and better shift management helped ensure people received their allocated care hours. Staff told us this had not always been the case. Care staff did not always receive sufficient training to effectively meet and support people's health conditions. Senior staff and management told us their induction was limited and did not give them the background information about the service or the people in their care.

People's care and support was provided by a caring staff team despite the organisational challenges from the provider. People told us they felt safe living at Napton House and they felt recent changes within the staff and management had begun to improve the service they received.

Staff worked within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, staff's knowledge ensured people received consistent support so the right decisions and outcomes were made. However, care records needed better documentation to show what decisions people had limited capacity and understanding to make. Staff told us and we saw, they sought people's consent before they provided care and support.

Some people were supported to pursue hobbies and leisure interests to keep them active although not everyone received support to promote and support positive behaviours through engagement and stimulation.

Most people prepared their own meals and did their own food shopping. Staff supported people to ensure they maintained a balanced diet.

People received support from other healthcare professionals and organisations but a lack of encouragement meant some people did not always benefit from external support.

Some people took responsibility for their own medicines management while staff supported others. Staff who supported people with their medicines were trained and provided people's medicines as prescribed.

We looked at examples of completed audits and checks that assured the provider, people received a safe, responsive and effective service. Some identified actions were not always recorded as completed, which made it difficult to know if improvements had been made. The new management team had not been at the service long and they told us there had been limited support through induction to help drive improvements promptly. The manager was in the process of understanding and prioritising what improvements they needed to focus on to make people's experiences at Napton House what the provider expected in line with their organisational aims and objectives.

We found the provider was in breach of the regulations related to staffing and good governance. You can see what action we have 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?

The service was not always safe.

People's needs were assessed and risks to their safety were identified but risk management plans required more detailed information, especially those promoting positive behaviours. Staff knew about safeguarding procedures and understood what action to take if they suspected abuse. People received their medicines safely and as prescribed from trained staff. There were enough staff to meet people's needs, however some people's care hours were not always provided at the times people needed.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff were not always trained to meet people's needs. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and supported people to make their own decisions. However, when decisions were made on behalf of people, there was limited evidence to show they were made in people's best interests. People were supported to maintain their health and staff involved other health professionals in people's care when needed.

Requires Improvement ●

Is the service caring?

The service was not always caring.

People were supported by staff who treated them with kindness, compassion and respect. However, the lack of consistent management affected the delivery of care despite staff's willingness to provide care and support when people required.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Care plan information was not always detailed which meant staff did not support some people in line with their physical and emotional needs. Staff did not always provide the care people

Requires Improvement ●

needed, as there had been limited flexibility for staff to support people outside of their agreed hours. The provider had a team that focussed on helping people with positive behaviour support but this was not always requested.

Is the service well-led?

The service was not always well led.

Systems to monitor and review the quality of service people received required further improvement. The systems used to monitor the effectiveness of the service were not effective and a lack of audit records meant we could not be confident actions were taken. Systems to monitor fire risk assessments, medicines checks, and staff training required further improvements. A registered manager was not in post and the lack of leadership from the provider had impacted on the quality of support people received.

Requires Improvement 

Creative Support - Warwickshire Supported Living Service

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 unannounced comprehensive inspection took place on 27 June 2018. The inspection was carried out by one inspector and an assistant inspector.

Before the inspection visit, the provider completed 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 found the PIR was not sufficiently detailed. We asked the manager during our visit to tell us what they had recognised worked well for people and what they had identified they wanted to improve.

We looked at information received from statutory notifications the provider had sent to us and from commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at this location. The commissioners shared information regarding the 'quality visits' they had undertaken which had identified shortfalls in the level of service, such as staffing levels, staff consistency and a lack of management and oversight of the service. We looked at these concerns during our inspection and found these inconsistencies had impacted on the quality of service provided. The commissioners shared action plans the provider was following to drive improvements so we could see what actions had already been taken and what they had begun to prioritise.

During our visit we spoke with two people living at the service and two staff who provided care and support. We were unable to speak with most of the people who used the service due to their health conditions or that they had gone out for the day. We spoke with a supported living manager who was responsible for the day to day management of the service who had been in post for six weeks and we spoke with the new manager who had been in post for two weeks. We spoke with a senior operations manager who was also new to this service, a service director and a senior quality practitioner.

We reviewed two people's care records to see how their support was planned and delivered. We reviewed records of the checks the staff and management team made to assure themselves people received a quality service.

Is the service safe?

Our findings

People we spoke with told us they felt safe and they enjoyed living at Napton House because they got on well with each other, they had their own keys to their flats, and staff were on hand to offer support when needed.

We found staff kept people safe and protected from poor practice. Staff knew the actions they should take if they had any concerns about people's safety. One staff member said, "I would tell you (CQC) and report it." Staff knew who to contact and were confident any concerns raised, would result in actions to keep people safe. The provider had submitted notifications to us when they believed people were at risk and they had taken the appropriate actions to ensure people remained safe.

A recent increase in staffing levels meant there were enough staff to support people which was confirmed by people and staff. However, some staff told us previously, people's care hours were not always given to people when they wanted them. One care staff member said, "Not everyone gets one to one as we have always had staffing issues. Now we have six staff it is better." Staff told us people's allocated care hours were matched to people's needs, but if people refused their care at those agreed times, "If they don't use it, they lose it." They explained that if staff had time they could defer those hours, but this had not always happened. However, they felt the increase in staffing levels would allow them more flexibility to achieve this. Staff said recent changes in how shifts were managed meant staff knew which people they were 'allocated' to which made sure people got the support they needed.

Risk assessments were not always reflective of people's support needs. The senior quality practitioner told us people's care and risk records needed reviewing and if they had been reviewed, people's freedom to do more things on their own would have increased. They gave us an example of one person who was known to leave the building without telling staff. They said, "Most of the time they would go to their parents so we could have a risk plan that says if they don't return, we do this, then that." Positive behaviour plans to guide staff in responding to challenging behaviours were not completed. Positive interventions would help in some situations but a lack of guidance for staff meant behaviours escalated and in some cases, had become physical so risks increased. We told the manager and quality practitioner but they could not give us an answer as to why they were not implemented.

People's medicines were administered safely by trained and competent staff. Medicines were stored securely in each person's own flat. Regular checks of medicines stocks ensured any errors were kept to a minimum and action was taken when an issue was identified. No time critical medicines were prescribed, but staff understood if they were, the importance of ensuring these were given at the right time. For people who had prescribed creams, staff recorded the date of opening so creams would be used within the expiry period so they remained fit for use. Where medicines were prescribed on an 'as required' basis, guidelines were in place so staff knew safe dose limits and amounts within set periods of time to ensure people were not over medicated.

Risks within the environment were not always managed safely. An external cleaning contractor cleaned the

communal areas once a week. During our visit the communal areas were being cleaned. We found the contractor had left unattended cleaning chemicals which presented an unnecessary risk to people at the service, especially as one person was identified as a risk because 'they could drink bleach'. Some cleaning products were in unmarked bottles so if any spillage or consumption had occurred, it was not readily known what treatment to provide to reduce the risk of injury. We told the quality practitioner on the day of our inspection visit who arranged for their removal so to reduce the risk further and the manager agreed to speak with the contractor to prevent this happening again.

During our visit, we saw the providers COSHH risk assessment (Control of Substances Hazardous to Health) dated 15 June 2018. This assessment recorded 'no one was at risk or increased risk for hazardous substances'. This was not correct. Following our inspection, the provider sent us a copy of their Health and Safety instructions for contract cleaners to follow when on site. This included all cleaning materials and cleaning fluids should be kept under direct supervision at all times and cleaning fluids should never be used in unmarked bottles to prevent accidental consumption. This was not followed or managed to reduce unnecessary risk to those using this service.

We did not see staff provide personal care, but staff understood and told us about the importance of good hygiene and safe infection control measures, such as using personal protective equipment where necessary.

Fire checks were completed but we found some had not been completed within the provider's expected timescales. Staff told us they recorded incidents and we discussed learning from events with the senior operations director and the quality practitioner. We were told these were not completed so there was a lack of overview and a lack of awareness to draw conclusions to limit further incidents.

Is the service effective?

Our findings

People were unable to tell us whether they felt staff were trained, but when we asked them how staff supported them, they had no concerns.

We spoke with the new management team and asked them about their induction as they had only recently started working for this provider. They told us they had raised their concerns with the provider's senior managers about the quality of their induction and the training available. They described an induction that did not fully prepare them for the role. However they commented that they could now see improvement.

People's day to day health, emotional and welfare needs were not always being met because staff were not trained in how to support and meet some people's needs. We asked the manager, supported living manager and senior quality practitioner about their training and whether it equipped them to meet people's needs. All of the responses showed us improvements were needed and in some cases, they had not received training since they joined the organisation. One of them said, "It is all booked though." We asked what training staff and management had to support people whose behaviours were challenging. They did not give us an answer, although one said, "Since I have started I have had no training apart from medication... we have been in such a crisis."

We found other staff did not understand how to support people with certain behaviours and they did not see how their actions affected those people in their care. This was confirmed when one staff member said, "We all have our own approach." Speaking with staff about how they managed specific behaviours, staff used past experiences or tried different methods to find a way that led to positive results. Because behaviour plans were not in place, there was no consistent approach from staff. One person who had behaviours that had become more challenging, described how they relied on structure and routine. This person told us how the inconsistent approach to them by staff had impacted on their behaviours (because of their underlying condition).

Another staff member they told us they had not received any manual handling training and they had been employed at this service for over 12 months. The staff member said they would not do any manual handling tasks and would seek support from another staff member. Following our inspection, a service director sent us their training schedule which recorded staff would cover manual handling on day three of their induction. Because some staff had not received a thorough induction, we could not be certain manual handling was provided to all staff in line with the providers expectations.

The training schedule confirmed what staff had told us about their training that showed staff had not received training in positive behaviour management even though, they supported people with behaviours that challenged. Speaking with staff, reviewing people's care plans for behaviour management and support within the organisation, there was no evidence positive behaviour support was known, understood and promoted. The director confirmed training in positive support management was planned but not until September 2018.

For people with other health conditions, we found staff had a lack of awareness and knowledge. One staff member told us they supported people in the service with epilepsy, and one of these people received personal care. Conversations with staff showed a lack of awareness in how they effectively supported people with this health condition. When we asked a staff member what they would do if the person had a seizure they said they did not know. We discussed the wider health condition of epilepsy with staff and found a lack of knowledge in how seizures needed to be monitored, potential signs, triggers and when they needed to seek other healthcare professional support. This meant staff may not have the knowledge to support people with epilepsy effectively.

This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. 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 provider had not submitted any community DoLS to us and people had no restrictions on their freedoms. The person who was known to leave without staff knowledge, we were told they were not on a DoLS, as their concern was more around safety than restriction.

People's capacity was not always assessed. In the care records we sampled we could not see people's capacity to make some decision had been assessed. Staff told us some people had limited capacity and people's records did not always support what staff told us. For example, one person living at Napton House had limited understanding of finances and staff managed this person's money through an appointeeship.

Following our inspection visit, the provider told us the person's social worker completed the appointeeship referral and any concerns about capacity, should have been assessed by the social worker. However, we would expect records to be held by the provider to show how this decision had been reached so they could be confident, decisions were made in their best interests. The senior quality practitioner recognised mental capacity assessments required improving, but told us other issues at Napton House had taken priority and this was an identified action that remained outstanding.

For other decisions where capacity varied, we asked if the impact of a person's wellbeing had been discussed with their appointee to see if anything could be done to enable the person for example, to take part in more meaningful activities for them. This was because the person's care records said they 'required lots of encouragement to engage in alternative activities as I spend long periods of time around Napton House not engaging in work or education opportunities'. We were told that this had not been explored.

Staff recognised the importance of promoting choice and we saw staff gave people the opportunity to make their own choice regardless of capacity. Staff said this was important because it was still a person's right to choose, even if they lacked understanding.

People's flats had their own kitchen area and they were encouraged to prepare their own meals and drinks to promote independence. Where people could not do this, staff helped prepare meals and support people where needed and encouraged people to eat a balanced diet.

People had access to other healthcare organisations but we found one example where a person had declined to attend some of their healthcare appointments. Some of these appointments were rescheduled

and in some cases, continued to be declined. There was no evidence to explain why they had been declined, or how the person had been supported to attend future appointments.

Is the service caring?

Our findings

People were relaxed in the company of staff and two people told us they felt the team of staff were supportive and caring towards them. Both people we spoke with told us they enjoyed living at the service.

Staff spoke to and about people in a caring and respectful manner, and people responded positively when staff interacted with them. We asked care staff what delivering a 'caring' service meant to them. One staff member responded, "I love my job because I have a passion for care." This member of staff told us they felt the support people received now had 'made huge progress'. They told us about one person who had previously received around 55 hours of support per week, but this had now reduced to 20 hours. They said this was because the person had been supported to be more independent and because of this, the person's wellbeing had improved because they were proud of themselves and their achievements. Another staff member said they enjoyed working at Napton House and said they felt staff were working more as a team under the new management which made it better for those living at the service.

People told us they were supported to be as independent as possible. We observed several examples of staff talking with people about what they wanted to do and how. Staff ensured people had the information they needed to make their own decisions, and encouraged people to do so. Some people living in the home were building their independence with support from staff, such as cleaning their room, preparing their own meals and drinks. One staff member explained how they found supporting and encouraging people was rewarding and they came to work at Napton House to 'make a difference'. Staff told us they enjoyed working at Napton House and understood the importance of putting people first.

People were supported to maintain relationships with their friends and families if this was what they wanted. One person had a meeting about their tenancy during our inspection visit and a family member was supporting them. One person said they visited their family for Sunday lunch and their family members visited them in their flat. People said they could bring friends and family into Napton House, although people told us they were encouraged to take them to their own rooms, rather than communal areas which they did not always like. Speaking with people and staff we could not fully understand why this 'rule' as described by the supported living manager had been imposed because we were given conflicting reasons. Following our inspection visit, the provider sent us a copy of a 'tenants' meeting held 2 June 2018 where people discussed the use of communal areas and what was expected.

The supported living manager said that the reason for this was that 'some of them can argue' and 'others can request things from staff when they may not have direct support'. Another reason given by staff was that 'some people can dress inappropriately'.

People told us they had forged positive relationships with others in the home. One person said, (pointing to another person living at Napton House) "They are my best friend" and the other person reacted positively to this comment. Staff were friendly and familiar with people in their care. However, during the day we heard one staff member refer to a person, 'Hello trouble'. The person and staff member joked however this may not always be appropriate when supporting people with certain behaviours or health conditions. If the

person responded positively to this, it should have been recorded in people's records that, that is what they prefer.

Despite staff's commitment to caring for people to a level they wanted to, we found other examples where actions had not made for a caring service, or that impacted on people's privacy and dignity. For example, the provider operated CCTV in communal areas of the home. We spoke with the senior quality practitioner, the manager and a supported living manager about how they sought people's consent. The supported living manager said the monitoring of communal areas was used to evidence what had happened when an incident had occurred, however we could not see people had given their consent to be monitored in this way. The management team had not considered the impact on people's privacy, especially as some people had disinhibited behaviours. The manager agreed to follow this up with the provider and speak with people living at the home. Following our inspection visit the provider held a 'tenants' meeting on 2 June 2018 and people agreed to the use of CCTV at Napton House.

Two people told us how staff spoke with them which they did not always like. One person said, "They speak to me like I am a child", and explained, "[Staff member] says 'go to your room, go to your room'." Another person said, "I don't like some staff but I stick with it." One person said they had raised their concerns to a senior staff member, but there was no evidence to show what action had been taken in response to those concerns. The person said they would not raise this issue again, "What's the point, nothing changes." We gave feedback to the manager and senior operations manager so they could take any actions necessary to respond to people's concerns.

Is the service responsive?

Our findings

People did not always receive a service that was responsive to their needs. The provider's website and objectives was to 'promote the independence, inclusion and wellbeing of people with care and support needs. We do this by working with the people we support, their families and partner agencies to deliver innovative, high quality services that meet individual needs and aspirations in a person-centred way'. We found the provider's objective was not always put into practice.

For example, one person living at the home was diagnosed with Asperger's Syndrome which is an autistic spectrum disorder. Part of their support was for staff to help promote and prompt them to do things for themselves, to promote a lifestyle that increased positive behaviours and to manage living in a domestic environment. An important aspect of this support was consistency of staff, but the person told us, "Changing staff a lot is not good, only a few stayed for over one year." They explained, "You get close to someone, they leave...how does that work. Management changes a lot and I am the only constant."

Some people had addictive behaviours to cigarettes or alcohol. Speaking with the senior quality practitioner they told us they had tried to help one individual manage their addictions, but with limited success. However, from what we were told by the quality practitioner, the support had been reactive rather than establishing, supporting and encouraging positive behaviours. For example, to help this person with alcoholism, the staff enrolled them on a local project, however the senior quality practitioner said, "We knew they wouldn't attend." The person had not attended and other measures such as enrolling with other organisations to help with drink addictions had not been explored or encouraged.

This person also had financial barriers that prevented them from doing activities they enjoyed. There was limited involvement, encouragement or ideas from staff as to how to enrich this person's outlook on life. As such, challenging behaviours increased which put the person and others at risk of potential harm. Our analysis of the person's records showed a key event may have been the start of increased challenging behaviours. There was no evidence to show any intervention or support from staff to understand why, or how to prevent this person's behaviours escalating further. We were told that the provider had a 'positive behaviour support' team who offered bespoke support to people and staff with behaviour management issues. We were told that 'people have to be referred in', but we found no evidence that this person had been referred for this support.

One person's care records showed staff had recorded their views about the person's care and how it could be enhanced. Records dated 11 May 2018 showed staff expressed concerns and dissatisfaction with the way this person's support hours were delivered. These staff felt that this person's support hours could be used in a more constructive and developmental way, encouraging the person to be more active and promoting their independence. There was no evidence to show this had been followed up.

People said they were involved in their care decisions and they felt the care they received had improved. Care records we sampled required improving, especially around decisions people could not understand, and how staff managed certain behaviours and risks for self-harm. This had been identified by the manager

and plans were in place to improve the care records.

During our visit, some people played puzzle games with staff. Some people went out with family and friends and one person told us they were attending a local show as a musical tribute act. People's rooms supported their hobbies and interests. One person showed us their room which was personalised around their preferences, with masks, pop memorabilia and games they enjoyed playing on their games console.

Is the service well-led?

Our findings

The provider did not have consistent and effective measures to ensure the service maintained good standards because the management and provider oversight of the service had been inconsistent.

A registered manager was in post from July 2017 to January 2018 and another registered manager was in place from March 2018 to May 2018 before they de-registered. This left the service with no registered manager at the time of our visit, which is a condition of their registration. Following the first registered managers departure in January 2018, the provider appointed a senior quality practitioner to provide management support. From speaking with them, it showed their responsibilities had changed to managing the service, rather than supporting a manager and reviewing quality work. Talking about their six months experience at Napton House they said, "A lot needs to change – documents don't support people's needs... not detailed" and, "People could do more for themselves with less input." They also said, "Staff morale had taken a dip" because of staffing levels, being reliant on agency staff and changes in management.

The provider had appointed a new manager who had been in post for two weeks at the time of our inspection visit and was in the process of applying to become registered with us. The provider had also recruited a supported living manager who had only been in post for six weeks and a senior support worker who had been in post for three weeks. The senior operations director had been appointed in March 2018. At this inspection, because those staff were all relatively new to the business, we did not always get complete responses to the questions we asked.

Changes with staff and management had affected the delivery of care. People were complimentary about the new managers but people said the changes in care staff and management, had affected the service they received. One person said, "There has been a lot of changes, it's hard to know who's who, even managers have changed." This person said consistency and routine was important to them and their keyworker had written a letter to the provider in May 2018 on their behalf expressing how staff and management changes had a negative effect on them.

Speaking with the manager, senior quality practitioner and supporting living manager they told us they found the service required improvements. All of them said their own induction to the service was not thorough and meant they had to learn and find things out for themselves, rather than have a plan to work towards. Being new to the service and not having an effective handover meant they were reactive to improvements. Commissioners had visited the service in April 2018 and found a number of concerns related to shift management, lack of mental capacity assessments, staff inductions, staff levels, care plans and staff training. The provider was working through an action to plan to address these issues, but some of these concerns had not been addressed.

During our visit we identified a lack of proactive management and leadership from the provider affected the quality of service provided. For example, systems for the oversight of care plans and risk assessments was in place, but some records of care plans and risk assessments were not updated or focussed on promoting positive behaviours. Staff confirmed some people did not always get their allocated 'care hours' because

there was limited flexibility in staffing levels to meet people's needs. There were no audits or checks to ensure people received the care and support they required.

The provider's audit process did not record what they had checked. For example, we looked at a medicines audit and asked how they assured themselves, people who self medicated, continued to take their medicines safely. There was no one at the service who self medicated who received personal care, however we were checking staff awareness and the effectiveness of the provider's processes. We would expect the service to risk assess how often they needed to check the person's ability to self-administer to ensure it was safe for them to do so. Staff did not know and we saw no records that showed how this was managed. Following our inspection the provider told us people who self medicated had reviews undertaken and their medicines policy told staff how to manage this ,however staff we spoke with, were unaware and the manager agreed to follow this up.

Health and safety audits were not effective. For example, one person's care records had identified they were at risk of 'drinking bleach' and this was identified in the commissioner's visit in April 2018. Health and safety checks were completed to ensure premises, equipment and staff practice was safe. However, during the morning of our visit we saw cleaning items such mops, cleaning fluids and flannels were left unattended in a communal corridor. Some cleaning items were in spray bottles with no warning stickers or guidance of what to do if these items became ingested or sprayed onto skin. COSHH (Control of Substances Hazardous to Health) Regulations require employers to control exposure to hazardous substances to prevent ill health. We found checks were not completed to ensure risks to people were minimised and the providers own guidance for COSHH and contract cleaners was not being complied with. Following the inspection visit, the manager told us the cleaning was completed weekly by an external contractor and they agreed to take this matter up with the provider to reduce the risks to people.

We found fire safety checks were not always completed at the required times. Monthly firefighting equipment records were not updated since 10 March 2018 and 'means of escape' checks were not recorded as completed since 22 February 2018. Good practice is to review fire risk assessments. The fire risk assessment for Napton House was due to be reviewed February 2018 but there was no evidence to show this had been completed. Following our visit, the senior operations director sent us an updated fire risk assessment that showed it was reviewed in May 2018.

Training records were sent to us following our inspection visit. These records supported what some staff had told us about training not always being provided so they had the knowledge to provide effective support. For example, staff had not been trained to support people with positive behaviours, which would help them to recognise what worked well and how to promote good care outcomes for people with a learning disability. Training records showed this training was not available to staff until September 2018. One staff member had not had moving and handling training and they had worked at the service for over 12 months. The records, together with the responses from staff, meant we could not be assured that staff had completed all the training necessary to support people living at Napton House. Following our visit, the provider confirmed the staff member had received moving and handling training.

People told us they had raised issues and concerns and these had not been addressed. When staff raised concerns about people's support hours in May 2018, there was no evidence their feedback had been responded to. Also, the lack of incident and accident analysis did not identify patterns or trends which may have supported some of the feedback we received that may have provided evidence of the quality of care people received, and how this may have caused increased behaviours in some people.

The local authority visited in April 2018 and our inspection visit showed the provider had not taken

responsibility to improve the care delivery within the home, whilst they experienced inconsistencies in management and staffing. Examples staff told us where people did not receive their allocated support, a lack of training and support for people with certain medical conditions or behaviours had not been identified showed people's needs were not always considered. For one person living at Napton House, the inconsistencies in their support and not providing the encouragement they needed to promote positive behaviours, had a detrimental effect on them.

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

Staff were complimentary of the new management and said recent changes had been for the better. One staff member said people were getting the support they needed, especially around promoting independence. They said this was because of the new manager's approach. Staff said recent managerial changes had a positive effect but they said for the last few months, it had been difficult to meet people's needs. One staff member said, "Not everyone has had their hours. ...always had staffing issues. Now it's better and they get their hours." We asked them why it had improved and how it affected people's care. They said, "Knowing your allocation now helps and leadership is better, we all lead a shift." They said staff were allocated to care hours so they knew who they were supporting.

During our inspection visit the manager accepted that closer scrutiny and improved governance was needed to help them to deliver good care outcomes to people. They wanted to empower staff and to make them more responsible.

The manager said they welcomed the inspection and would make the improvements because they wanted to deliver a good service. The senior operations manager said the previous registered manager was responsible for this service and another service which had a negative impact on the quality of care provided. They explained the new manager would become registered manager across five services. However, they said the new management structure now included a supported living manager in each service managing on a day to day basis, which would ensure the provider's standards and expectations would be met.

The provider had submitted statutory notifications to us since their registration which is their legal responsibility to do.

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively by the provider to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17 (1)(2)(a)(b)(e).
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had received the appropriate training and support to consistently meet people's needs effectively. Regulation 18(2)(a)