Our TLC Limited

Redburn House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 21 March 2016 and was an unannounced inspection. This meant the provider had no prior notice of our inspection. The service consists of Redburn House which provides accommodation and personal care for up to ten people with mental health needs. In addition, the provider had a separate registration for personal care which allows it to provide services in the community. Supported living services are provided at seven properties, where staff aim to support people to rehabilitate and develop life skills.

On the date of the inspection there were 29 people using the service.

A registered manager was in place. 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.

During our previous inspection in August 2015 we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to Good Governance, Safe Care and Treatment and Staffing. As part of this inspection we checked whether improvements had been made in these areas as well providing an updated rating for the service under the Care Act 2014. At this inspection, we identified the provider had not made the required improvements and was still in breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were still not managed in a safe way. Stock levels of medicines did not match with what was recorded as present, meaning some medicines were unaccounted for. Some medicines were not given in line with the prescribers instructions.

Safeguarding procedures were in place which staff had a good understanding of. People we spoke with told us they felt safe living in the home and when cared for in the community. Some risks to people's health and safety were assessed with clear plans in place. However there were some notable admissions with a lack of risk assessments in place detailing how staff supported people safely whilst taking them out in the community.

Incidents were not always managed in a safe way. We saw where medication errors and behavioural incidents had occurred robust preventative measures were not always put in place. We were concerned that behavioural incidents had occurred where staff had not received appropriate training.

There were sufficient staff to ensure people received an appropriate level of care and support whilst allowing them to maintain a level of independence.

Although recruitment procedures had been improved shortly before the inspection, we were concerned that

a staff member had been recruited in an unsafe way in November 2015.

Some areas of the premises were not safe as they had not been adequately checked and maintained by staff.

We were concerned about the managers understanding and application of the Mental Capacity Act and Mental Health Act (MHA). There was a lack of monitoring of a person's care and as such as change in their circumstances had not been identified by the service.

People had access to a range of health professionals and we saw their advice was regularly sought for example over behaviours that challenge or health conditions.

Staff had received basic training in a number of subjects. However there were a number of key omissions with a number of staff not receiving even basic training in subjects such as behaviours that challenge and mental health awareness.

We observed the lunchtime and saw the food looked appetising. However we identified that nutritional risks associated with one person were not well managed by the service.

Staff were kind and caring and treated people with a good level of dignity and respect. Care was delivered by a stable group of staff who knew people well. We observed care and saw some good examples of kind and compassionate care.

Initiatives were in place to involve people in daily tasks around their house and promote their independence within the community. The service helped people at Redburn House to move out into the community and develop their skills although there was a lack of structure to these plans.

Care records were in a transitional phase and as such we found them difficult and confusing to navigate which meant there was a risk of inappropriate care and support being provided.

People told us they were satisfied with the service and had no cause to complain. However improvements were needed to the way the complaints procedure was brought to the attention of people who use the service.

The service had failed to ensure significant improvement to its quality following our previous inspections in May 2014 and August 2015. The service had failed to adequately address risks within the timescales stated on action plans submitted to the Commission.

Some systems were in place to assess and monitor the quality of the service, however these were not fully embedded or not sufficiently robust to identify and improve the service.

Staff told us morale was good and said they felt well supported by the organisation. People's views on the service were regularly sought through a range of mechanisms.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. You can see what action we asked the provider to take at the back of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to

cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Since the last inspection, significant improvement had not been made to the way risk and incidents were managed. Medicines were not managed in a safe and proper way.

We identified the premises at Redburn House were not consistently managed in safe way and some areas were in dis-repair.

There were sufficient quantities of staff available to ensure people received appropriate supervision.

Is the service effective?

Requires Improvement

The service was not always effective

We were concerned about the managers understanding and application of the Mental Capacity Act and Mental Health Act. There was a lack of monitoring of a person's care and as such as change in their circumstances had not been identified by the service.

Staff had received some training however there were still gaps in training provision notable challenging behaviour and mental health awareness.

The food at Redburn House looked appetising and people had input into the menu. However, we were concerned that one person was not protected against the risks of inadequate nutrition.

Is the service caring?

Good

The service was caring.

Most people told us that staff treated them well with a good level of dignity and respect. This was confirmed in the interactions that we reviewed between people and staff.

The service helped promote people's independence by

encouraging them to do more for themselves and support them to live in the community.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records contained plenty of information on people's needs but this information was often conflicting and staff were not fully aware of which care plan to follow.

People were encouraged to build links with the local community and build relationships with other people who used the service.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to act on our feedback and ensure sufficient improvement to the service since our previous inspections in May 2014 and August 2015.

Some audits and checks were carried out but these systems were not yet fully embedded and robust enough to fully identify risk and improve the service.

Redburn House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also followed up on breaches of regulation identified at the August 2015 inspection.

The inspection took place on 21 March 2015 and was unannounced. The inspection team consisted of three adult social care inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with eight people who used the service, five support workers, the cook, the activities co-ordinator, two management support staff, the registered manager, compliance manager and the provider.

We visited Redburn House where nine service users live and are provided with care and support by support workers. We also visited three supported living properties where care is delivered by community staff.

We looked at elements of five people's care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority.

Inadequate

Is the service safe?

Our findings

During this inspection we checked whether improvements had been made to the safety of the service following the August 2015 inspection. We found risks still remained that had not been adequately addressed.

We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines but some aspects did not fully comply with current guidance. For example the policy did not fully describe how covert medication should be administered or the process to create an acceptable legal framework. However, we saw evidence of a revised document nearing completion which referred to the National Institute for Health and Care Excellence (NICE) guidance "Managing medicines in care homes guideline (March 2014)."

Medicines were administered to people by trained care staff yet our observations at Redburn House demonstrated one care staff's practice, whilst being caring and sensitive to people's needs, fell short of an acceptable standard.

We observed the morning medicine round at Redburn House and inspected the management of medicines at two of the provider's supported living premises. No person was receiving their medicines covertly, but the care worker knew the principles of covert medicine administration and was keen to stress this would be a last resort.

We witnessed some medicines being administered without observing the prescriber's wishes. We saw two people were prescribed medicines to be administered 30 to 60 minutes before food yet on both occasions we saw the medicines administered after breakfast. Our subsequent discussion with the care worker and the registered manager gave us confidence the matter would be attended to.

We carried out an audit from a random sample of five medicines dispensed in boxes or bottles at Redburn House to account for their use or accuracy of recording. On four occasions we found discrepancies. For example on one occasion we saw a person had been prescribed tablets of Co-codamol. The MAR sheet recorded the service receiving 100 tablets. We looked at past MAR sheets to the point the Co-codamol was dispensed and found no record of any administration. Our audit found 87 tablets in stock with no evidence of when the remaining 13 tablets had been administered. We saw another person had been prescribed Paracetamol, one to two tablets to be taken on an 'as necessary' (PRN) basis. Whilst staff recorded administration of the medicine we saw they did not consistently record the dose administered. This shortfall added to staff not carrying forward stock from one MAR chart to the next and made it impossible for us to reconcile current stock levels.

At Redburn House, we found one person was prescribed Zopiclone at night on an 'as required' basis. We found stock levels had been check on 16 February when 23 tablets were recorded. Since that date we found no record of administration yet only 22 tablets remained. Likewise the same person had been prescribed Cyclizine. Stock levels had been checked on 16 February when 29 tablets were recorded. Since that date we

could find no record of the medicine being administered yet only 28 tablets remained. Subsequent scrutiny of daily care records did not reveal any occasion when the medicine had been offered or refused. This meant these medicines were either administered without records being kept or were otherwise unaccounted for. This demonstrated unsafe management of medicines.

Routine stock balances were not kept on the MAR charts both in Redburn House and in the community increasing the risk of discrepancies of these types not being promptly identified. We were especially concerned as at the last inspection in August 2015 we also found adequate stock control measures were not in place.

We saw all 'as required' (PRN) medicines were partially supported by written instructions which described situations and presentations where PRN medicines could be given. For example each person had a protocol prepared by a pharmacy for all prescribed PRN medication. However the guidance was commonly incomplete. For example, we saw a person was prescribed Diazepam PRN. The protocol recorded 'one tablet to be taken daily as directed by the prescriber when required' (see care plan). The pharmacy had also recorded the reasons for administration as 'see care plan'. We asked a care worker who administered medicine to show us where in care plans the additional advice was recorded. Despite a rigorous scrutiny of the care records by the care worker and ourselves we could find no further guidance. This meant there was a risk these medicines would be given inconsistently by staff.

Our audit of boxed medicines in the community showed some medicines were in boxes from various previous dispensing. For example we found one person had been prescribed Diazepam 2mgs. The box contained the correct number of tablets but contained blister strips from two different manufacturers with different expiry dates which did not correlate with the expiry date on the box they were contained in. The registered manager assured us the practice would be stopped immediately.

This was a breach of Regulation 12 (1) (2g) of the Health and Social Care Act 2014 Regulations.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date. We saw evidence people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on MAR sheets were signed by care staff.

We inspected medication storage and administration procedures in Redburn House. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge temperatures were taken daily and recorded.

Risk assessments were in place which assessed some of the risks to people's health and safety at Redburn House. For example, one person persisted in smoking in their room despite being told this was not allowed due to fire risk. Care records showed the issue had been recognised and a risk mitigation plan had been put in place. We saw one of the mitigating actions was to ensure all bed-linen was flame retardant. We spoke with the person about smoking in their bedroom; they were keen to tell us they knew they should not do so and they confirmed flame retardant bedding had been provided by the service. Staff we spoke with were

familiar with these assessments.

We found some risk assessments were not in place for people who lived at Redburn House. For example one person had a history of misusing substances. Although the manager was able to demonstrate to us how they were managing these risks, this was not formally recorded in a structured risk assessment risking an inconsistent approach from staff. Two people displayed behaviours that challenged and were taken out into the community by staff. However they did not have risk assessments in place stating how staff would manage the risks associated with their behaviour whilst in the community.

At the last inspection we identified that clear actions were not put in place following safety related incidents. At this inspection we found some improvements had been made but risks remained. Incident records contained more detailed investigations and preventative measures. However this was not universally the case. For example following a medication error at Redburn House, although there was evidence action had been taken to check the person was safe, there was no investigatory focus on how the incident would be prevented in the future.

We also identified a number of incidents which had occurred at Redburn House in March 2016, which had not been recorded and investigated as incidents. The registered manager told us they had been busy and not yet had chance to formalise these, however without a prompt investigation there was the chance these incident could re-occur.

The service managed people with behaviours that challenge and mental health problems. Staff we spoke with on the day of the inspection were aware of the risks people presented and were clear of the action they needed to take to keep people safe. However on reviewing incident records we saw behavioural incidents had not always been managed appropriately. Incident records showed an incident occurred in Redburn House in January 2016 where a member of staff had been assaulted by a person who used the service. The staff member had no previous experience of working in care, there was no record of an induction to the service and at the time the staff member had not received any training in mental health or managing behaviours that challenge. We were particularly concerned as the outcome was that the staff members' response to the person was a contributing factor to the incident. We identified another incident had occurred where a staff member's behaviour had been identified as a contributing factor; again they had not received any training in mental health awareness or behaviours that challenge. This was particularly concerning as in the August 2015 inspection we also raised concerns that staff had not received training in behaviours that challenge.

We completed a tour of Redburn House and inspected three people's bedrooms and various communal living spaces. Heating to the home was provided by covered radiators thus protecting vulnerable people from the risk of a burn from a hot surface. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We saw upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows.

However some areas of Redburn House had fallen into disrepair and required action to ensure people were kept safe. We found some carpeting was heavily soiled, worn and ill-fitting. This was particularly so on the main staircase where the carpet posed a trip hazard. We saw some people's bedrooms and furniture was damaged with, in some cases, broken sharp plastic exposing people to potential injury. Whilst accepting the damage had been done by the occupant of the room, the risk still remained. We saw one room had no means of artificial lighting as no bulb was in the light fitting. The responsible individual told us they would replace the bulb. In another room we saw part of the doorframe was missing. The occupant told us they had

done the damage by kicking the door. We saw various areas of damage to the home as a result of deliberate actions of people, however our tour demonstrated the management team had no knowledge of recent damage. This showed effective environmental checks were not a regular and effective feature of the service.

This was a breach of Regulation 12 (1) & (2a,b,c,d) of the Health and Social Care Act 2014 Regulations.

We reviewed fire safety records and maintenance certificates for the premises and found them to be compliant and within date.

People told us that they felt safe and well cared for in the home and in the community. Staff told us they had been provided with safeguarding training and throughout our discussions they demonstrated their understanding of the different types of abuse people could experience. All the staff we spoke with were confident if they reported an incident of abuse the manager would take appropriate action. A member of care staff showed us where they would source information to enable them to make a safeguarding referral in the event of unacceptable practice. A safeguarding log was in place which recorded and ensured action on any safeguarding incidents which occurred within the service. We saw evidence safeguarding incidents had been correctly reported to the Local Authority Safeguarding team and Commission. We saw evidence follow up actions had been taken for example through liaising with health professionals to discuss behaviours that challenge. Where appropriate, thorough disciplinary investigations had been conducted to help keep people safe. Staff we spoke with had a good understanding of how to identify and act on concerns and most staff had received training in safeguarding.

We identified risks associated with the way a person had been recruited to the service. Records showed a staff member had been recruited in November 2015, however their Disclosure and Barring Service (DBS) check had not been completed until December 2015. Furthermore on reviewing their DBS we saw a criminal conviction was recorded. The provider had no record of this conviction and had not conducted a risk assessment demonstrating why this staff member was suitable to work. This also meant that the recruitment decision was made before having full view of the DBS check, which demonstrated unsafe recruitment practices which was in contradiction to the provider's recruitment policy. We were particularly concerned as we raised issues with the robustness of recruitment documentation during the last inspection in August 2015. The registered manager assured us the conviction would be reviewed and a risk assessment undertaken.

This was a breach of regulation 19 (2) of the Health and Social Care Act (2008) Regulated Activities Regulations 2016.

Since February 2016 through a service improvement plan we found recruitment procedures had been made more robust with a more structured process in place and a dedicated member of staff now responsible for the process to ensure improvements were made. We reviewed more recent new starters and found evidence DBS checks had been completed or were being obtained before staff started work. References and checks on people's previous qualifications took place.

We found there were sufficient staff deployed to ensure safe care both at Redburn House and in the community. People we spoke with told us there were enough staff around should they need assistance. Staff told us there were enough staff to ensure people received timely care and support. Arrangements were in place to ensure staff were provided to cover sickness and holidays. Staffing levels were carefully planned at Redburn House and in the community. Rotas' showed planned staffing levels were consistently maintained from day to day. During the inspection we saw enough staff to ensure the right balance of

supervision and encouraging people to develop the independence.

Protocols were in place in case of emergency. We saw in one person's care records that if they left the premises, staff were to follow a protocol, which is a protocol for alerting police if someone goes missing. This demonstrated that staff were using appropriate techniques for the person. However, we saw that not all staff had signed to demonstrate understanding of the assessment.

Requires Improvement

Is the service effective?

Our findings

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 application procedures for this in care homes 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. The Care Quality Commission (CQC) also monitors services were people's liberties may be restricted under the Mental Health Act (MHA) 1983.

The registered manager told us one person living at Redburn House was subject to an authorised DoLS. We were also told the same person was subject to a Community Treatment Order (CTO). CTO's were introduced to the Mental Health Act 1983 by the Mental Health Act 2007. These orders allowed people to be discharged from being detained in hospital into a community setting whilst still being subject to mandatory conditions. Any breach of these conditions could lead to recall into hospital and detention under section 3 of the Mental Health Act 1983. The manager told us one of the conditions of the CTO was for the person to take their medicines. Whilst scrutinising care records saw a letter from the person's solicitor dated 15 December 2015 which informed the person the CTO had been withdrawn. The letter had been filed without the registered manager being aware of its content. We were concerned that the person had been administered medicines for three months by staff who believed the CTO was still in place with the condition medicines had to be taken to comply with the CTO. This meant the service was not effectively monitoring this person's care and treatment as it was unaware of their change in circumstances. This meant there was a risk this person's rights were not protected as staff still believed they could administer medication to the person under a CTO that had been withdrawn.

Furthermore, because of this lack of recognition of the change in the person's circumstances the service had failed to complete a mental capacity assessment to determine whether the person had the capacity to consent to staff administering medication to them.

This was a breach of Regulation 17 (1) & (2a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service had identified one further person who may lack capacity and may be deprived of their liberty at Redburn House. On this occasion the correct procedure had been followed. They person was awaiting a mental capacity assessment before the service made a DoLS application. This followed discussions between the registered manager and the CPN (Community Psychiatric Nurse), and consultation with the person's family. This reflected that the service was in this case following the correct procedure.

We asked the registered manager if anyone living at Redburn House was without anyone other than paid

carers to help them make decisions or provide support regarding reviewing of care needs. We were told one person was without any family or friends. We spoke with the person and found them to struggle with understanding what their care choices might be. We found the degree of their disability due to mental illness was significant. Scrutiny of care records showed that no-one other than paid care staff had participated in setting care needs or reviewing them. The registered manager agreed that the provision of an advocate would ensure a degree of independence existed to represent the person's needs; however we were concerned this had not been considered by staff at the home.

We saw that the food served at Redburn House looked tasty and people said they enjoyed it. The food at lunchtime was cooked by a volunteer who worked in the kitchen during the week and although they had received food hygiene training, they had not had any formal training on nutrition and dietary needs. We asked them about their knowledge of dietary supplements and foods to use or avoid and they had limited understanding of this. They were aware of the dietary requirements of most people through care workers informing them, although we saw no dietary information in the kitchen.

We were concerned that nutritional risks to one person living at Redburn House were not effectively managed. Staff told us the person was nutritionally at risk and was given a nutritional supplement on a daily basis. This was documented in the care plan. We checked the weight chart for the person and found they had put a reasonable amount of weight on in the last few months, but had lost a small amount of weight again in February 2016. Staff were completing a food and fluid chart for this person to ensure they received a good diet. We looked at these charts and saw that nothing had been documented for their breakfast, although staff told us they had a full cooked meal. At lunchtime, we heard the person say, "I don't like sausages." No alternative was offered; the person left the sausages on the plate which was eventually removed. We saw written in their care plan that the person was to be 'encouraged to choose a meal of their own choice'. This showed a lack of personalised care and choice and staff not following the plan of care. In addition, when we checked the food chart, it indicated they had eaten all their food including the sausages. This meant the service was not keeping an accurate record of this person's nutritional input potentially placing them at risk.

The fluid chart for this person indicated they should be supported to achieve a target of 1500mls per day. However the actual amount documented was an average of 600mls for the last few days. This had not been flagged up as a risk by the service. This showed that risks to this person were not being appropriately identified and mitigated.

This was a breach of Regulation 12 (1) & (2a) of the Health and Social Care Act 2014 Regulations.

People we spoke with both at Redburn House and in the community generally spoke positively about staff and said they had the right skills and knowledge to care for people. For example one person told us, "All staff are capable, no issues or complaints with them." We found staff displayed a reasonable knowledge of the subjects we asked them about such as safeguarding. At the last inspection we had concerns that staff had not been provided with timely training. At this inspection we found some improvements had been made, for example staff had received face to face medication training and fire training to address deficiencies. Most staff were now up-to-date with safeguarding and moving and handling training.

However the provider had failed to ensure staff were up-to-date with all training. Mental health awareness and challenging behaviour training was provided to some staff via e-learning, however this was basic e-learning which we concluded was not sufficient to assist staff to manage the people living at or being cared for by the service. Following the last inspection, the manager told us they had planned to arrange for face to face training to be delivered but this had not been possible. Some staff had not received even basic training

in these subjects. For example at Redburn House, four support workers had not received any training in challenging behaviour and seven had not received training in mental health awareness. Only four staff had received training in MCA/DOLS, with the registered manager, and five support workers staff not receiving any. This lack of MCA/DOLS training was also raised as an issue at the previous inspection. This was also the case for community staff with a number of staff not receiving training in the Mental Capacity Act, and on mental health and challenging behaviour.

This was a breach of Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received recent supervision and appraisal, the staff we spoke with told us they were happy in their role and felt well supported by the organisation

People told us the service helped them access healthcare services. We saw evidence of this in care records for example records of liaison with health professionals such as psychiatrists and general practitioners. This information was used to inform plans of care to help provide staff with information on how to meet people's healthcare needs.

Good

Is the service caring?

Our findings

Overall we found people were treated with dignity and respect by friendly and kind staff. Most people told us staff were kind and caring and said they were treated with dignity and staff. For example one person described staff as, "Hard-working and pleasant." Another person told us, "The staff do a lot for us. I like it here." A third person told us, "I like the staff." However one person said, "Some of them are really not nice on some occasions." We concluded these were isolated comments and did not find any other evidence to corroborate these concerns. We spoke with people living in the community who told us staff were kind and offered the right balance of support and allowed them to live their lives.

We saw that staff had a good rapport with people and the atmosphere in the service was relaxed. People looked relaxed in the company of staff and our observed conversations demonstrated people had confidence in discussing many aspects of social and private life with staff. We saw staff speaking to people to give encouragement and praise. We witnessed care being delivered with compassion, for example in the administration of medicines. We saw some people were suspicious of medicines yet the care worker persisted and gave people confidence to eventually take their medicines. We saw people and staff sharing jokes and general conversation. We saw a staff member diffuse a situation when a person started to become verbally aggressive by suggesting the person went for a walk with them, which they did. The person returned to the lounge later, apologised for getting angry and appeared calmer and happier.

We spoke with a person who told us staff were supporting them move to a shared house. We saw the person talking to staff about how to progress this, and asking their advice. The support worker discussed the matter in a way to facilitate the person to reach their own decisions. This demonstrated to us that the service encouraged people to air their views in relation to their care and support. As part of a recent safeguarding investigation people had been asked for their detailed views on staff within the home. People's views were sought through other mechanisms such as 'resident meetings' and people were consulted on the menu within the home.

We talked to staff and saw they had a good knowledge about people, their likes and dislikes. This was developed through a low turnover of staff who worked regularly with the same people. For instance, one staff member told us about how they had used their knowledge about a person's hobbies to break down barriers and build a relationship with them. Life histories had been obtained for people who used the service to help staff deliver personalised care.

People who used the service at Redburn House were encouraged to develop and maintain their independence. For example they were encouraged to participate in cleaning and cooking around the home and many people entered and left the house freely. People were able to make their own choice of drinks from a hot water system in the dining room. Staff in the community were able to give us good examples of how people's independence had enhanced by the service, although this was not always robustly evidenced within care and support plans.

Requires Improvement

Is the service responsive?

Our findings

We looked at a number of care records; these contained assessments of people's needs in areas such as mental health, activities, diet and nutrition and washing and dressing. These were currently in a transitional phase with old care and support records being replaced with a new format. However this made care records confusing as it was difficult to locate current and relevant information. Some information was not dated and conflicting information was recorded within some files. For example, within one person's records it was unclear whether they still engaged in drug use. Some staff also told us that care records were confusing for example one staff member told us, "We don't know which care plans we are following." There were also a number of blank or incomplete documents. Social activity monitoring records were in place for some people. However these were not up to date; for instance one person had no activities recorded for the last three weeks. There were also no updated and documented development goals for people. We saw a plan was in place to complete the revamp of care plans within the next few weeks.

This was a breach of Regulation 17 (1) (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw examples of responsive care by attentive staff. One person at Redburn House had dressed themselves in many layers of clothing and staff suggested to them they may get too hot. Eventually the person was persuaded by a member of staff to go to their room and change their clothing. When thye returned, staff complimented them on how they looked and they smiled and looked happy at this.

The service aimed to help rehabilitate people and develop their life skills through care in Redburn House and in the community. At Redburn House, staff and records showed us each person had a day allocated in the kitchen, according to their abilities to help support and develop their skills. For instance, one person enjoyed cooking and baking and was planning to help cook a chilli the following day. Another person helped with the washing up or setting the table. One person made their own food at lunchtime, which they had purchased themselves. This demonstrated the service encouraged personal preference, as well as helping people to gain independence.

People we spoke with told us the service gave them the appropriate mix of freedom and support. For example one person told us of their ambitions and told us staff were helping them to achieve this. We visited people in the community and spoke with people who had moved from Redburn House to more independent living. They told us they felt independent and had responsibility for their own cooking, cleaning and personal affairs, although staff were able to offer support if needed. We were told of examples by staff where people had developed for example in building up the confidence to cook for themselves. However care plans did not contain measurable goals to provide a structured and stepped approach to achieving goals over a period of time. This also meant there was no evaluation of whether people had achieved their goals.

Daily records provided evidence that people were supported to socialise, go shopping and maintain links with the local community. People receiving care and support were encouraged to socialise with other

people who used the service, for example through visiting people who lived at other properties where staff delivered care. One person told us how they enjoyed visiting another property because it made a nice change for them. They told us how people in the houses got on well together. The provider also ran a domiciliary care service which supported people with social inclusion. Some people who lived at Redburn House used this service to access the community and get involved a range of social activities.

The service had a volunteer activity organiser in place one day a week and they were keen to encourage a range of activities. We saw that most of these involved a cost and many were external activities. Activities on offer included tai chi, boxercise, personal training and ice skating, dependant on interest shown, and fortnightly quizzes in the service. Meals out were being planned on a monthly basis and the activity organiser was hoping to help plan a trip to Blackpool.

We asked people if they knew how to complain if they had an issue. People said they were happy to talk to staff about concerns, although one person said they didn't feel they were listened to adequately. There was no clear and robust complaints procedure in place at the time of inspection. Complaint forms for service users were kept in the dining room at Redburn House but these had run out and we did not see any clearly visible in the community. This highlighted that the service was currently not providing sufficient opportunity for people to log complaints. However, the registered manager showed us that a new complaints procedure was being implemented and were able to show us the relevant documents. They told us a service user guide would be in the care plans and this mechanism would improve the way the complaints procedure was presented to people.

Inadequate

Is the service well-led?

Our findings

A registered manager was in place. Most statutory notifications had been submitted to CQC such as notifications of abuse. This helped us to monitor events which occurred within the service. However the Commission had not been notified of the DoLS authorisation in place for one person who used the service.

Staff both in Redburn House and the community told us they were happy in their role and that morale was good. A staff member said, "I enjoy working here;" and another said, "I love it." We spoke with a number of staff about the leadership within the service. One staff member said, "If I had a problem I'd go to the manager;" and another said, "I definitely feel supported by management." All the staff we spoke with felt the management team were approachable and they were listened to.

The provider had not effectively improved the service in a timely manner based on our feedback. Prior to the inspection, a complete review of the provider's management structure had taken place. New management support had been recruited with responsibilities for driving improvement in areas such as care plans, recruitment and training, quality assurance and the adoption of new policies and procedures. However this process was only in its infancy and as a result we identified similar failings as in the May 2014 and August 2015 inspections.

At the last inspection in August 2015 we found policies and procedures were not being followed or were not up-to-date. At this inspection, the registered manager told us they had not managed to update their policies and procedures in a timely way. Two weeks before the inspection, a new quality assurance system including new policies and monitoring tools had begun to be introduced, however this was not yet fully implemented and a hybrid of old and new tools and policies were being used. The provider told us they would have the new system up and running within a couple of weeks, however we were concerned that this had not been actioned in a timely manner following our previous inspection.

At the previous inspections in May2014 and August 2015, we found a complete and accurate record of each service users care was not present with care records lacking clarity and/or duplicated. At this inspection, we found this was still the case with care plans in a transitional phase, with a mixture of document types being used.

In May 2014 we identified that audit tools had not been effectively utilised since the registration of the service in September 2013. At this inspection, some improvements had been made, for example medication audits and financial audits were being carried out, but risks still remained and audits were not yet sufficiently established or robust. Medicines audits were not sufficiently robust as they had not identified the unsafe medicine management practices that we identified during this inspection. The provider had recently changed its format of care plan audit but only one had been completed under the new format and most people's care records had not been audited recently both in Redburn House or the community. One environmental audit had been carried out at Redburn House in February 2015 but this was just written up as notes in the registered manager's notebook rather than a robust audit against defined criteria with clear actions. This was particularly significant as we identified risks associated with the premises and

maintenance which the management team were not aware of. On the inspection date, we established there appeared to be a credible plan to provide more structured audits in the future, however we were concerned this was still not fully in place despite us first raising it as an issue in May 2014.

At the last inspection we raised concerns that no comprehensive audit was undertaken to ensure compliance with regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found this had not yet been done. We found the home was not meeting the standards in a number of areas making this omission more significant.

At the last inspection in August 2015 we identified problems with the ways incidents were managed. We found this was still the case with robust and detailed preventative measures and investigations not carried out in a timely way.

At the last inspection we found staff had not been provided with timely training. Following this, the provider sent us an action plan which stated that training in behaviours that challenge and DoLS/MCA would be provided without delay. At this inspection we found some staff had received basic training whilst others had not received any training at all. The manager said they had been trying to arrange face to face training but they had experienced delays in providing this.

We were encouraged by some of the systems we saw in development such as a tracker to monitor and analyse the number of incidents, accidents and complaints. Management support staff had a clear indication of the systems and processes they wanted to put in place and how they were going to achieve this. However we were concerned that this had not been fully achieved 30 months after the service opened. For example there was not yet analysis of incidents occurring at different areas within the service. We saw induction checklists were now in place inducting new staff to the policies and procedures and ways of working. However this was a recent addition, and had not been implemented until 29 February 2016 despite us raising it as a concern in August 2015.

We also found that there had not been a staff meeting since our last inspection in August 2015. We saw one had been planned but it had never taken place. We looked at the agenda which had "CQC inspection August 2015" as an item. We were concerned the inspection findings had not been discussed with staff through this mechanism despite the provider assuring us it would be compliant with the relevant standards by November 2015.

This was a breach of Regulation 17 (1) (2a,2e) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

Management meetings were held to discuss strategic improvement and a more robust management governance structure was being introduced to hold individual managers to account for specific areas of practice and performance.

People's views were regularly sought on the quality of the service. The provider had undertaken recent quality assurance surveys with people who used the service. These asked people for their views on a number of quality initiatives linked to the five CQC domain areas. We saw outcomes were mostly positive. Periodic house meetings were held with people to get their views on the service and involve them in things such as activities and menus.

A service improvement plan was in place. We saw for example there were plans to further improve the service, prioritising care plan documentation including care plans and risk assessments over the coming

weeks. We saw it had been recognised the staff were not up-to-date with training and a plan had been put in place to address this. Whilst this was encouraging it should have been fully actioned at an earlier date following our previous inspection.