Turning Point

Turning Point - Follybridge House

Inspection report

Bulbourne Road
Tring
Hertfordshire
HP23 5QG

Tel: 01442828285
Website: www.turning-point.co.uk

Date of inspection visit:
18 February 2019
19 February 2019
20 February 2019

Date of publication:
22 May 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

About the service:
Turning Point-Follybridge House is a residential care home registered to provide personal care up to six people who have a learning difficulty. At the time of our inspection five people lived at the service. The service was a large home, bigger than most domestic style properties. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service:
People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Where appropriate, advocates were employed to support people with making choices about their lives.
However, whilst people had individual support to exercise choice and control, this was limited by the wider environmental factors which inhibited people being included and playing an active role in their local community. The service was located on a busy main road with no pavement. There were no local amenities apart from a pub. This did not fully reflect the principles and values of Registering the Right Support. This meant the people living in the service experienced limited independence, and inclusion.
There was insufficient management input into the service to guarantee positive outcomes for people. The unsatisfactory management presence meant the service had not maintained its rating of good. This was because the provider had failed to monitor and review how care was provided, the performance of staff and the environment in which people were living. We have made a recommendation about staffing levels.
The environment had not been maintained in a way that reflected respect for the people living in the service. This was highlighted when labels were placed on people's bedroom furniture to direct new staff where their clothes were stored. Inadequate maintenance had put people at risk of harm. The unhygienic environment meant people and staff were placed at risk of infection. Equipment had not been maintained in such a way as to be safe to people. In parts the environment of the building was unsafe, for example no window restrictors on one set of upstairs windows. We have made a recommendation about the premises.
Fire precautions were not all suitably maintained to ensure people's safety was protected. Due to a lack of response from the provider we were not assured people were kept safe from the risk of legionella. Records related to the safe administration of medicines were not always accurate.
Medicines were not always stored securely.
Records related to the care of people were not always up to date or accurate. People's health needs were not always documented.
Systems to ensure the safe employment, training and support for staff were not always followed. Gaps in candidate's employment histories were not always investigated, staff training and competency assessments were not always completed.
People's care plans reflected how they wished to be cared for, information included their personal preferences.
The registered manager knew what was required of them but had not been supported to carry out their role

effectively. During our visit the team manager took immediate action to rectify as many things as was practicable. We found the registered manager and the team manager to be honest and open and they were cooperative with the inspection process. We have made a recommendation about the duty of candour, to ensure staff understood their responsibility to apply this to their work.
Information was being recorded in a respectful and dignified way about the people being cared for. Where records were up to date they were clear in their content and provided appropriate direction for staff in how to care for people. Where required assistance from external professionals was requested.
People's health care needs were monitored. People had Health Action Plans in place which highlighted all their health needs.
Staff told us they felt supported by senior staff, even though they were disappointed at the amount of time the senior staff spent in the service. We observed the registered manager and the team manager had a strong working relationship and supported each other well. Overall the staff in the service were caring. They told us they worked well as a team. Mostly they respected each other and supported each other.

Rating at last inspection:
The previous inspection was carried out on the 26 May 2016. (Published on 30 June 2016). The service was rated Good at that time.

Why we inspected: The inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:
The inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

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

For more details, please see the full report which is on CQC website at cqc.org.uk

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 safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-Led findings below.	**Requires Improvement**

Turning Point - Follybridge House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by an adult social care inspector.

Service and service type
Turning Point-Follybridge House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced, which meant they did not know we were coming to inspect the service.

What we did
Before the inspection we reviewed the information we held about the service which included notifications they had sent us. Notifications are sent to the Care Quality Commission (CQC) to inform us of events relating to the service which they must inform us of by law. We looked at previous inspection reports and reviewed the Provider Information Return (PIR). The PIR 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.
During the inspection we spoke with seven members of staff including the registered manager; the team

manager; the locality manager; the senior quality advisor and three support workers. We observed staff interacting with people and supporting them. Some people were unable to tell us about their experiences of living at Follybridge House because of communication difficulties. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records relating to the management of the service including two people's support plans and associated records. We reviewed the medicine administration records for five people and inspected three staff files including recruitment records. We checked records of accidents and incidents. We reviewed minutes of meetings and a selection of quality assurance audits and health and safety records. We asked for the registered manager to contact people's families so we could speak with them. However, they only managed to obtain the consent of one relative. Following the inspection, we spoke with the local authority commissioners.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse; assessing risk, safety monitoring and management.

• During our inspection we found many areas of concern. Two new showers had been installed in the premises. Both reached 48 °C when switched to a "hot" setting. The Health and Safety Executive stated in Managing the risks from hot water and surfaces in health and social care, "If hot water used for showering or bathing is above 44 °C there is increased risk of serious injury or fatality." We made the management aware of the problem. Following the inspection, we were told notices had been put up in the bathrooms for staff not to use the "hot" setting when assisting people to shower. This did not mitigate the risk of accidental use and scalding and therefore the risk continued.

• We found hazardous cleaning materials such as sulphuric toilet cleaner, a razor blade and shampoo in an unlocked cabinet in the upstairs bathroom. A staff member agreed these were a risk to people and arranged for them to be stored securely. On the second day of the inspection we visited the bathroom to find the razor and shampoo were in the unlocked cupboard again. This meant staff had not taken preventative action to protect people from harm as they continued to store dangerous items in the bathroom.

• In the bathroom a pile of broken bathroom tiles laid on the side of the bath. We were told these had fallen off the wall. Their edges were sharp and pointed and could easily have caused injury. On day two of the inspection we saw these had been removed.

• Throughout the house we found the accommodation was not clean or hygienic. Walls were dirty and stained in places. In the kitchen the cupboard under the sink was very dirty, the seal around the hand washing sink was absent. This was an infection control risk. In the bedrooms we found net curtains were dirty and discoloured. Windows were unclean, cobwebs were present on the walls and dirt on the floors, skirting boards and window sills evidenced the lack of cleaning and hygiene. When we brought this to the attention of the team manager they arranged for the service to have a deep clean.

• In one spare bedroom on the first floor we found there were no window restrictors. The room was unlocked. In one person's care file we read a risk assessment stated the person could "Climb through windows ... has no perception of danger or consequences." We reported this to the team manager. They subsequently locked the room until window restrictors were put in place.

• In the dining room we found wires sticking out of the wall. We were told this was a broken plug socket and the wires were live. It had been temporarily taped over, but the tape had become unstuck. The live wires were not covered sufficiently to prevent electrocution. When we spoke with the team manager, they told us approximately a month before, they had reported this to their maintenance department but they had taken no action. Whilst we were present they made a phone call and the plug socket was fixed by the second day of our inspection.

• In the garden, paving slabs were un-even and moved when stepped on. This proved to be a trip or fall hazard for people. We found unwanted broken furniture in the garden, which was unsightly and hazardous.

• A fire inspection carried out in October 2018 highlighted a fault with the intumescent strips on the fire

doors. The record stated, "The same doors would not be capable of preventing the spread of fire and smoke, thus potentially affecting persons making their escape." The maintenance department believed the work had been completed, however it was obvious it had not. We were informed by email on 21 February 2019 the necessary work had been carried out on the fire doors.
• Two people had diabetes. There were no risk assessments in place to ensure the care provided was appropriate, and safe. There was no diabetic hypoglycaemia (low blood sugar levels) pack available should the person experience hypoglycaemia. There were no care plans in place regarding the associated health risks of diabetes such as eye and circulatory problems. We were told the GP practice had recognised the need for staff training and a diabetic nurse would be visiting the service soon.
• Following the inspection, we asked for and received a copy of the Legionella inspection report completed on 17 January 2018. It stated, "The previous risk assessment was reviewed during this site visit with previously identified high risk factor actions still outstanding." The previous visit had taken place in 2016. We asked for evidence to be sent to us to demonstrate the outstanding actions had been completed. We were sent copies of recorded temperature water logs. We were told "We have also completed water testing/sampling which due to IT issues I am unable to send to you a copy of results, as soon as the issues are resolved I will send you a copy of this. All other actions are still pending due to availability of specialist parts." We did not receive any further information. We could not be assured people were safe from the risk of legionella infection.

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

Staffing and recruitment.
• The provider had a recruitment procedure in place which included carrying out various checks on candidates prior to their employment. Recruitment documents did not always identify or record the reasons for gaps in candidate's employment histories. Without this knowledge the provider could not be assured of their safety to work with people. The locality manager advised us they would add a prompt to the employment checklist to remind managers to check for gaps in employment histories as part of the recruitment process. Whilst the team manager was in the premises there appeared to be sufficient numbers of staff present. However, we were told by one staff member there were often shortages of staff that meant people could not attend the day service as there was no driver available. They told us "It used to be the manager or the deputy who would cover, but now they have to prioritise out of the four services where they are spending their time. "

We recommend the provider reviews the staffing numbers in the service.

Using medicines safely.
• Staff received training in the administration of medicines to people. However, we found several concerns related to medicines.
• Each person had a medicine cupboard in their bedroom containing the medicines they required. These cupboards should have been locked to ensure the security of the person's medicines. However, we found three of the cupboards had been left unlocked. We pointed this out to the team manager who ensured all the cupboards were locked. Appropriate action was taken with the staff member who was responsible for the medicines on that day.
We also found three discrepancies between the number of medicines recorded as stock and the number of medicine available to people. For example, for one person, records told us there should have been 28 Lorazepam tablets in their cupboard. We found there was more than 56.
• We checked the medication administration records (MAR's) of the people living at the service. We found them to be up to date, although they appeared accurate the stock did not balance.

• For two people medicines required for pain and one for anxiety were out of stock and had not been reordered. We found the service had not picked up the issues we found regarding medicine management. The last medicine audit was completed in September 2018. We discussed this with the team manager who acknowledged the medicines audits were not carried out frequently enough. The last audit had been completed in September 2018. They planned to increase the frequency to every month.

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

• Photographic identification was available for all people receiving medicines and allergies were recorded.
• A protocol had been written and signed by the GP for people who had been prescribed "when required "medicines (PRN). This enabled staff to know when and how people should be offered these medicines. For example, Paracetamol for pain relief.

Preventing and controlling infection.
• From our observations we were concerned about the risk of transferring infections. For example, a bin in the bathroom used to dispose incontinence pads was broken. Although this had been identified in the infection control audit carried out on 2 January 2019 no action had been taken to address the problem.
• We also found the inside of the cooker was covered in food spillages and was unhygienic. We were informed a deep clean of the ovens took place after the inspection.
• Food was not safely stored, for example beef burgers in the freezer were not sealed, and a bag of rice was open in a cupboard. The kitchen was in a state of disrepair. The covering of one cupboard door was broken. Paint was peeling around the window frames. According to the last infection control audit completed on 2 January 2019, "Furniture fixtures and fittings are visibly clean with no visible debris, body substances dust or dirt". This was not accurate and in accordance with our findings. There was no separate cleaning audit. These conditions placed people at risk of infection.

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

• Staff were provided with training in infection control. We saw they were provided in personal protective equipment (PPE) such as gloves. They understood the need to take precautions such as hand washing to minimise the risk of spreading infections.

Learning lessons when things go wrong.
• When accidents occurred, these were recorded on a data base and the information was shared with senior managers and the risk and quality assurance team. They reviewed the information and occasionally requested further information or updates from the registered manager or locality manger. Records showed in some instances requests for updates were dated 31 March 2018 but had not been responded to. This meant there was a lack of scrutiny and accountability in relation to the information being shared and how lessons could be learnt.
• An audit of infection control audit took place on 2 January 2019.The audit stated, "chairs and couches are free from rips and tears." We saw large areas of the couch and chairs had been ripped, exposing the foam filling.
• Records showed when equipment became broken or unsafe the senior staff acted by notifying the appropriate department or contractor. However, where there was a delay on the part of the contractor or department to respond, there was a failure on the part of senior staff to follow this up in a timely way. This meant the processes for checking the safety and suitability of the premises, equipment and the environment were not effective. This placed people at risk of harm.

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

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance
• 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
• Although restrictions were in place such as the front door being kept locked, there were no DoLS in place. An application for each person had been made to the supervisory body but these had been refused. Records stated the restrictions were in the person's best interest and did not require authorisation.
• Care plans evidenced mental capacity assessments had taken place. Where a person lacked the capacity to make decisions for themselves a best interest process was followed. However, records did not clearly evidence what action was taken in the person's best interest. Following discussions with the senior staff they agreed this was something that would be clearly documented in the future.
• Staff received training in MCA and DoLS. Some of the new staff had not yet completed their training at the time of our visit but would be covering this topic as part of their induction training. The more experienced staff had a clearer understanding of the Act and how this was applied to people's lives.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs had been assessed and care plans and risk assessments were in place to guide staff. Care plans reflected people's physical and psychological needs, however, we found they were not always accurate in the information they held. For example, one person's plan stated they received 1:1 care 24 hours per day for seven days per week. However, when we spoke with senior staff they told us this was not correct. The person received 1:1 support when attending the day service. The plan also stated the person was "non-verbal" and then it stated the person could speak using single words.
• Another person's care plan stated they had Parkinson's disease. We asked the team manager if this was correct; they were unsure. The registered manager told us they thought it was correct. There was no

guidance or plan in place to help support the person with this area of need. Following the inspection, we were told by the provider "On review it was found that the document referencing Parkinson's Disease was missing the preceding word 'suspected'. The records and information were therefore inaccurate." This placed people at risk of harm.

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

Staff support: induction, training, skills and experience
• New staff received an induction and completed the care certificate when they were employed into the service. The care certificate is an identified set of standards that health and care professionals adhere to in their daily working life. The training matrix and staff training certificates showed that neither of the two night staff had been assessed as competent to administer medicines. One had not yet completed the training. People needed as required (PRN) medicines at any time day or night. Records showed staff who were sleeping in at night had received the necessary training to administer medicines.
• The training for the three new staff was not documented on the matrix as they were carrying out induction. However, for the other five staff, 30 percent of their eLearning training and 45 percent of their face to face training was not up to date or had not been completed. For one staff member sixty one percent of their overall training was out of date or had not been completed.
Training such as moving and handling of objects was noted as "not available". Only one staff member had up to date moving and handling training.

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

• Supervision was available to staff. Records showed this had mostly been carried out in line with the provider's expectation of every two months. Staff told us they found this useful. Staff felt supported by senior staff, and could contact them to discuss or raise concerns.

Supporting people to eat and drink enough to maintain a balanced diet
• People's nutritional needs had been considered by the service. Where people were at risk of choking care plans documented how food should be prepared, for example, cut into small pieces. We observed people being supported with a drink and a snack. Staff knew how to give support appropriately.

Staff working with other agencies to provide consistent, effective, timely care
• Records showed where people required support from external professionals this was provided.
• Guidance received from professionals was documented and applied to the care provided."
• The GP worked closely with the service to ensure people's health was maintained.

Adapting service, design, decoration to meet people's needs
• The service operated over two floors. Two people had their bedrooms on the ground floor as they were unable to use the stairs to access the first floor. From observing people, it was apparent they were familiar with the layout of the building and how to access areas. People's bedrooms had been personalised and reflected their interests and personalities. Some parts of the building had not been maintained, for example, in one person's bedroom the skirting board had rotted. Only one out of four light bulbs in their room was working.
• A large blue electrical insect killer had been fitted to the wall in the lounge This was more likely to be found in a commercial setting rather than a residential house. It was not in keeping with the décor or the function of a lounge. We were told this was due to a high volume of flies in the summer. Little consideration had been

given to the placement, design or aesthetics of this piece of equipment.

• We recommend the provider seeks advice from a reputable source on creating an environment that meets people's individual needs by the adaptation, design and decoration of premises.

Supporting people to live healthier lives, access healthcare services and support.
• The provider's PIR stated each person had a "Health Action Plan" in place highlighting all their health needs." These were reviewed regularly. People were supported to have annual health checks and medicines reviews. Staff could contact the GP for advice if they had concerns about a person's health. Records showed staff observed people for any changes in their health and took appropriate action. A record was kept of all external professionals' visits and appointments.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

● People were protected from avoidable harm and abuse. Staff received up to date training in safeguarding people. During our conversations with them they could demonstrate their knowledge of what action to take if they had concerns someone may be being abused.
Senior staff knew how and when to report concerns.

• The provider had an equality policy and staff had received training in equality and diversity awareness. However, we had concerns about the way one male staff member spoke to a female staff member. Their tone and attitude was not respectful. Two staff, one male and one female, told us there were problems with this staff member and the way they spoke and behaved with colleagues. We spoke with the team manager about what we had observed. We were told this had been addressed by the registered manager. We expressed our concerns that the situation was clearly on-going. We were assured by the senior staff appropriate action would be taken.

• People were treated with kindness by staff. From our observations we could see staff knew people well and were able to pre-empt their needs. For example, offering a drink and a snack.

• Feedback from one relative was "The attitude of the staff is very good, I have been very impressed, they seem to be very caring."

• On the first day of our visit we spent one hour and twenty minutes seated in the lounge completing a SOFI. There were three people present but no staff. A member of staff sat in the office which was adjacent to the lounge. The office door was open, people repeatedly left their seats and went to the office. The staff member said "Hello" to them and they then returned to their seat. The television was on but nobody was watching it. Eighty four percent of the time we were sat in the lounge there was no interaction between staff and people. One staff member called in occasionally to check people were alright. The interactions that took place between staff and people during this time were neither positive or negative, but neutral. One staff member explained their absence. They told us they had been asked to clean the house because we had found it dirty. As a result, people were left unsupported. This did not demonstrate people's individual needs were being well supported.

• The staff team was made up of people from differing cultures, backgrounds and religions. Staff told us they felt respected by their colleagues and the senior managers, regardless of their culture or religion. The team manager told us how they took into consideration staff needs when setting the rota. For example, where possible staff who practiced Islam did not work on Fridays. Where staff practiced as Seventh-day Adventists they were shown the same respect regarding Saturdays.

Supporting people to express their views and be involved in making decisions about their care

● One section of people's care plans referred to "How I would like you to support me." This gave staff a clear

description of how the person preferred their personal care to be carried out. It also gave staff information about the areas the person was independent in and what areas they needed support.
• One relative told us their family were communicated with if any changes in care were required.
In the PIR we were told when necessary an advocate was used to support an individual with decisions about their care or welfare. An advocate had worked with a person to design an end of life care plan. This enabled people to be involved in decision making about their care which included their preferences.

Respecting and promoting people's privacy, dignity and independence
• In people's bedrooms we saw labels were used on people's wardrobes and drawers indicating where their clothing was stored. For example, trousers. We asked the staff member if these were to assist people to locate their clothes, they told us the labels had been introduced to help the new staff in the service, not the person whose room it was. People had not been consulted or consented to the labels being stuck on their furniture. This was not a person-centred approach and did not show respect for people's or dignity.
• Apart from this example, staff knew how to protect people's privacy and dignity and encouraged independence. People were supported to be as independent as possible. Aids and adaptations had been applied to increase people's autonomy. For example, grab rails had been fitted in the bathroom along with raised toilet seats.
• The PIR stated people "…are encouraged and supported to prepare their meals and drinks when they so choose." We did not observe this happening, but we did observe people being supported with their drinks and snacks in a way that encouraged their independence.
Staff could describe to us how they preserved people's privacy and dignity and understood the importance of treating people this way.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Our observations of the service indicated to us the service was not consistently meeting people's needs. Records did not show consideration of people's health needs had been explored and the necessary training for staff and resources had not been put in place to ensure people's health needs could be met.

• One relative had recently been involved in liaising with the service about their family member. They felt comfortable and confident the service would involve them in decision making when needed. Records reflected contact with family members to discuss different aspects of people's care. Care planning had a holistic approach. It focused on the person, including their goals, preferences, interest and hobbies.

• We were told people had enjoyed day trips to Southend and Brighton. Other activities included painting, music and going for walks and picnics. One person liked helicopters, we were told the service was planning to take them on a helicopter ride. A greenhouse in the garden was used by one person to grow vegetables in the summer. Photographs showed how much enjoyment they got from this activity.

• The service met the Accessible Information Standards. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. They had identified and recorded how people communicated. For example, one person had communication difficulties when it came to expressing pain. The PIR told us staff with the assistance of the Speech and Language Therapist (SALT) had put together cards using symbols to alert staff when they were in pain. It also stated, "Actual objects of reference, pointing, Makaton (the use of signs and symbols), facial expressions and body language" were used to assist people to communicate. Each person had their preferred method. We saw visual weekly timetables and menu plans were in place for people.

Improving care quality in response to complaints or concerns

• We were told there had been no complaints received in the last year. The PIR stated "People are being listened to and the provider has an accessible form to support service users with communicating any complaints." Any complaints were talked through with people in monthly well-being meetings with key workers.

• Staff told us they knew how to deal with complaints and gave appropriate examples of how they would do this.

End of life care and support

●People had end of life care plans in place. Where people were not able to discuss their preferences, information had been gleaned from their personal life histories, to reflect their choices. Where appropriate, families had been involved in discussions around people's end of life care.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

• One relative and staff told us they felt the service was well led. The staff referred to the abilities and knowledge of the registered manager and team manager. The focus of the senior staff was on person centred care and high-quality care, but this had not been achieved. Due to the lack of management presence the standard of care was not always safe. For example, the open medicine cupboards and lack of cleanliness throughout the service.

• Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We had not received any notifications from the service since June 2016.

• There is a legal requirement for providers to be open and transparent. We call this duty of candour (DOC). Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was meeting the requirements of this regulation.

We found there was a culture of openness and honesty. Records of staff meetings confirmed incidents were discussed, this allowed the staff team to share thoughts and learn from each other. The registered manager was aware of the duty of candour and their responsibility to implement this. The service had a duty of candour policy. The registered manager told us they planned to discuss with staff in a team meeting how this related to their role and their responsibilities.

• We recommend the provider seeks advice from a reputable source regarding the training of staff in duty of candour.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● The registered manager was registered with CQC to be the registered manager for two registered locations one of which being Follybridge House. We were told along with the team manager they were responsible for overseeing four services. This reduced the amount of time they could spend in the service and resulted in a lack of management oversight. Staff told us the senior staff were "Not here often," "We have phone contact with [team manager] every day and they visit approximately twice per week or every day if there is an issue, then they go. They will stay for a whole day if we are short of staff" They went on to say "The [registered manager] visits about once a fortnight." They told us "There used to be a manager on site and a project

worker, they were like a deputy, from Monday to Friday. That structure is no more."
• Staff were concerned about the welfare of the senior staff one told us "My observation is the enormous pressure on these two guys, there is no home life balance….Our team manager and [registered manager] are under enormous stress, this impacts on the staff not having them here. It is having an impact on the staff and our performance, it will have an impact on the service users."
• We found both the team leader and registered manager were knowledgeable about the people living in the service and the staff. However, due to the limited time spent in the service, they were unable to resolve issues. Maintenance issues that had been reported had not been completed.
• Each day a support worker was assigned the role of shift leader. They were expected to manage the service without any extra training or authority to do so. One staff member told us staff were not happy about this. This was not a safe or effective way to manage the service.
• Quality assurance systems were in place. There was an annual audit completed by the senior advisor of the risk and quality assurance team in May 2018. Their comments included "A more robust monthly medication audit should be used. This has been sent to the manager," "Some health issues require support plans" and "Please ensure that any gaps in employment is clearly evidenced on file." We found these and other areas had not improved in the nine months since the audit.
• Competency assessments had been completed in the safe administration of medicines. However, we found the comments on the form used to record the observation had been completed prior to the test. This meant the record was not a true reflection of what the observer saw. The infection control audit completed on 2 January 2019 did not reflect our findings. For example, it indicated "Chairs and couches are free from rips and tears" and "Cleaning regimes are: Regularly monitored and reviewed." The cleaning schedules did not include daily, weekly, monthly or annual cleaning requirements. One staff member told us it was due to the lack of management presence that things were not up to standard. They said, "We as members of staff can only report things, we don't have the authority to make things happen."

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
●Staff shared with us their desire to offer a high-quality service to people. Comments included "I enjoy working here, we work well as a team." Staff meetings were used to discuss practice, and reinforce training and consider how best to achieve positive outcomes for people. Information was shared at these meetings to ensure staff were kept up-to-date of any developments or changes. Staff had an opportunity to meet and share experiences and knowledge through staff meetings.
• Staff told us they were treated equally by senior staff, comments included "I was off for a while, [registered manager] contacted me. It was a couple of years ago now but I have never forgotten it." Staff told us they were treated well by senior staff and felt supported. The team manager told us, "This is an inclusive service. We don't discriminate. We have had staff thank us for the way we have treated them."
• Because of our lack of contact with family members we could not ascertain how fully families had been involved and engaged with the service.
● People had access to a variety of activities in the community including day centres, cinema, pubs and the countryside.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to provide such appropriate support, training, professional development to staff as is necessary to enable them to carry out the duties they are employed to perform Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide care in a safe way Regulation 12 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h)

The enforcement action we took:

We issued a warning notice for improvements to be made by 31 May 2019.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); Regulation 17 (1) (2) (a) (b) (c) (d) (i) (ii)

The enforcement action we took:

We issued a warning notice for improvements to be made by 31 May 2019.