Woodham Enterprises Limited

Woodham House Daneswood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 20 and 24 July 2017. The inspection was unannounced on the first day and announced on the second day.

Woodham House Daneswood provides accommodation, supervision and support for up to 15 males with enduring mental health needs, some with a forensic history. At the time of the inspection there were 15 people using the service.

People have their own rooms and en suite facilities in the home. There is a shared communal kitchen, lounge and an activity room that is located at the rear of the large garden. CCTV is in operation in communal areas.

The last focused inspection took place on 24 May 2016 where we found that staff were not taking sufficient breaks between shifts and there was no registered manager in post. The service was rated requires improvement.

During the comprehensive inspection on 25 August and 3 September 2015 the service overall was rated good but requires improvement in well led because the service did not have a registered manager in post.

At this inspection the service had a registered manager in post who was present on both days we visited. 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.

Systems were in place to manage risks and safeguard people from abuse. There was detailed guidance in place for staff to follow and manage incidents but we found this was not always followed. People told us they had no concerns with their medicines and staff had received training on how to manage people's medicines but we found that medicines were not always managed safely.

The home required cleaning and appropriate steps were not always taken to ensure the prevention and control of infection. The home environment needed repairs, however, plans were in place to address this.

Pre-employment checks were not completed thoroughly to ensure the suitability of the staff employed. Staff had access to appropriate training to meet the needs of people who used the service. People's opinions were mixed about staffing levels and the provider was in the process of recruiting more staff. Night staff were working excessive hours that meant that they may not have received sufficient rest to meet people's needs safely.

The principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were

followed and for one person a DoLS application had been submitted and a best interests meeting planned. However, consent was not always sought from people about decisions affecting their use of areas of their home.
Staff promoted people's privacy and dignity and maintained confidentiality. People using the service and their relatives told us they were supported by caring staff and the staff spoke positively about working in the home. People were referred to healthcare services as required but health action plans required more comprehensive information.

People's views were mixed about the meals that were provided and some people told us meals did not meet their nutritional needs. Suitable arrangements were in place to ensure people received enough food and drink.

People's care plans and risk assessments were updated to show where there had been a significant change in their circumstances. Some people actively participated in activities that promoted their independence and safety in the community and dependency tools were used to monitor their recovery. However we found that the provider did not fully document how people attained their overall goals. People spoke about the things they enjoyed but there was insufficient evidence to demonstrate how staff supported them inside and outside the home. There was a plan in place to support people to move on to more independent accommodation where appropriate.

There was a complaint policy in place but this did not accurately identify the organisations that people could escalate their complaints to. People knew how to make a complaint but some people did not want to put this in writing and the provider did not keep a record of verbal complaints made about the service and how these were resolved.

Audits were not robust and did not pick up the issues we identified. People had the opportunity to voice their concerns but the feedback that was sought from people to obtain their views and comments regarding the service had not been evaluated to inform improvements at the service. Staff spoke positively about the registered manager and they had kept the Care Quality Commission (CQC) informed of any notifiable incidents that had occurred. The provider had links to other agencies who spoke positively about the service and worked in partnership with the service to deliver appropriate care.

We have made four recommendations about seeking and acting on people's views about their nutrition, access to areas of the home, managing complaints and person centred planning. We found four breaches of regulations relating to the management of risks to people's health and welfare, fit and proper persons employed, person-centred care and good governance. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Staff had received medicines training and their competency was regularly assessed.

Safeguarding procedures were in place for staff to follow to protect people from abuse; however the procedure for reporting incidents in one instance was not followed.

Risk guidelines were developed to manage risks to individuals, but some records did not always demonstrate how these were followed.

Rotas showed that night staff were working excessive hours, however the provider was recruiting for more staff to ensure staffing levels were sufficient. Background checks carried out to check if staff were suitable for their roles were not always robust.

Appropriate steps were not always taken to ensure the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they were not always involved with the preparation and choice of their foods. Meals were provided to ensure people received sufficient food and drink.

Where a person lacked capacity to make certain decisions best interests decisions had been made in accordance with the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). However, consent was not sought from people about access to areas of the home.

People's health needs had been assessed by healthcare practitioners, but health action plans required more detail about their healthcare needs.

Effective arrangements were in place to ensure staff had access

to the appropriate training and support.

Is the service caring?

Good

The service was caring.

The majority of people told us that staff were caring. Relatives told us they were happy with the care and support staff delivered at the service.

People had received an induction making clear what they could expect from the service and what was expected of them and they told us their privacy was respected.

Staff spoke positively about their role and were enthusiastic about the care they provided and ensured that confidentiality was upheld.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People knew how to complain and had access to the complaint procedure; however verbal complaints were not recorded so we could not be assured that these were responded to and resolved.

Care plans were designed to meet people's individual needs, interests and hobbies to promote people's well-being.

Referrals were made to the relevant agencies to support people's reintegration into the community. However, records did not contain sufficient information to measure people's progress and development in key areas.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring systems were not effective as they had failed to identify the shortfalls we found.

Systems were in place to obtain people's views to improve service delivery but these had not been evaluated to support improvement. The registered manager was committed to making changes to the service.

The registered manager was visible in the service and the staff spoke favourably about their leadership.

The provider worked in partnership with other agencies to promote people's independence and safety in the community.	

Woodham House Daneswood

Detailed findings

Background to this inspection

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

We visited Woodham House Daneswood on 20 and 24 July 2017 to undertake a comprehensive inspection of the service. The inspection was carried out by one inspector on both days. The inspection was unannounced on the first day and we informed the provider we would be returning for a second day to continue with the inspection.

Prior to the inspection we checked information that the Care Quality Commission (CQC) held about the service which included previous inspection reports and notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant incidents reported by the provider.

We spoke with a representative of the South London and Maudsley NHS Foundation Trust (SLAM) to obtain feedback about how the provider delivered their service in the borough of Lewisham.

During the inspection we spoke with six people using the service and a health and social care professional who was visiting on the first day of our inspection. We spent time observing the care people received, listened to a staff handover and toured the building. We reviewed the records in relation to five people's care including their medicines records, four staff recruitment files and information relating to the management of the service. Additionally we spoke with two support workers, the deputy manager, the service manager and the registered manager.

After the inspection we also spoke with two relatives and two health and social care professionals to gather

further information about the service and people's experiences.

Requires Improvement

Is the service safe?

Our findings

People we spoke with raised no concerns about their medicines and told us, "I take my medication which is more than what most people do." and "I go for my depot, I don't take my medicine here."

Despite this feedback, we found that medicines were not managed safely. We checked how people's medicines were managed on the second day of our inspection. The provider had a separate treatment room to store people's medicines. The room was kept locked and was observed to be clean and tidy. There was a separate medicines cabinet that contained medicines, such as ointments, liquids and tablets. However, there were no thermometers or air conditioning in the room to ensure that medicines were being stored at the correct temperature. There were no records in place for staff to record the ambient room temperatures of the clinical room daily. The room was warm and the window was closed. Medicines should be stored at the correct temperature to ensure the quality of medicines is not compromised. The registered manager agreed to act on this as a matter of urgency.

There was a specimen signature sheet that was signed by the staff. Medicines administration records (MARs) were typed and printed by the provider and the registered manager explained that the pharmacy did not provide pre-printed MARs. These had been signed by staff to provide assurance that people were receiving their medicines when required. However, we found the applicable codes were not printed on the MARs, for example, to show where people had refused their medicines or when they were away from the home. The registered manager assured us these would be updated.

People's files contained individual guidelines for the safe administration of 'as required' medicines, for example, paracetamol. Records showed that staff had recorded on the MARs for people when these had been given and the reason(s) why. We saw that protocols were in place for medicines taken 'as required', and had enough information to guide staff on what dose of 'as required' medicines to give. For two people, we found that the guidelines were dated August 2016 and noted these were due to be reviewed within six months of this date. However we found these guidelines had not been reviewed in line with the provider's written guidance. This meant staff would not have been following up to date guidance about how people should be supported with 'as required' medicines.

The registered manager told us that two people had diabetes. We looked at the PRN guidelines for one person diagnosed with diabetes because this person was prescribed medicines to control their blood sugar levels and records showed this had been given as prescribed. However the plan indicated that staff should administer an additional dosage of the medicine if the person's blood sugar levels increased however there was no information to evidence how this was monitored or if the additional dosage of medicine had been given. Therefore we could not be assured that risks associated with this person's diabetes were managed safely.

People's medicines records contained a one page summary called a drug administration record. This was to list people's sensitivity and intolerance, diet and special instructions about people's medicines, however for three people we found information on these records was not completed. There was a photograph on the

profiles to identify the person to help prevent medicines errors but we found that the pictures for three people were not clear and we could not easily identify who the people were. Therefore staff did not have a clear picture of each individual to support safe medicines administration.

We saw that audits had been carried out and had picked up issues in relation to gaps found in the MARs but these did not identify the issues that we found. This meant we could not be assured that people were being safely supported with their medicines.

At the last focused inspection of May 2016 we found that staff worked long shifts without sufficient breaks. At this inspection we found that the provider had followed our recommendation but we identified further concerns.

Staff rotas and minutes of staff meetings demonstrated that sufficient breaks were being taken during shifts and staff were allocated enough days off their working shift patterns. However, when we reviewed the rota over one month and calculated the weekly hours that staff worked we found that night staff were working, for example from 50-70 hours per week. . One person said about the night staff, "Sometimes I knock on the office door and I have to wait for ages before they answer, sometimes they are sleeping."

We checked staff employment contracts and found that the staff's weekly working hours on the rota far exceeded the amount of hours they were employed to carry out. Additionally there was no information to show that night staff were authorised to work in excess of their contracted hours. This meant that staff may have been too tired to carry out their duties effectively and keep people safe. We pointed out our findings to the registered manager who showed us that the service had an availability book where staff wrote their names down for any additional shifts they were able to do, however there were no systems in place to monitor how many additional hours staff were working. The registered manager agreed to reduce these working hours, monitor this more closely and have further discussions with the head office about staff employment contracts.

The issues highlighted in the above nine paragraphs constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a system for medicines disposal. The pharmacist stamped the provider's disposal of medicines forms to confirm the receipt of the surplus medicines and we saw records of this. However, we found there was a liquid medicine for one person that was no longer used. Their records showed this medicine was stopped after a discussion about the person's medicines during their ward round but this had not been disposed of. The registered manager agreed to dispose of this medicine right away. For a second person we found that two medicines were stored in the cabinet but were not recorded on the person's MARs. After the inspection the registered manager sent us a notification to state the person had been discharged from the hospital with these medicines on the date of inspection and the MAR was going to be updated.

Training records demonstrated staff had completed medicines training and observational competency assessments were carried out to assess staff's skills. One member of staff explained if they were unsure about people's medicines they referred to the British National Formulary (BNF) to check information about the medicines and associated side effects. There was a separate file that contained information about people's allergies. Staff had daily handover meetings to discuss people's medicines, as well as team meetings. The home had a system for receiving and dealing with medicines errors and we saw records to show appropriate action was taken by the registered manager in relation to this.

Safe and thorough recruitment procedures were not always followed to ensure that staff were suitable to

work with people using the service. Pre-employment checks were completed to assess the suitably of staff before they were employed to work with people who used the service. However, we found that in two out of the four files we viewed employment gaps had not been explored. For one staff member the references held on file had no recorded dates showing when they began and ended their previous employment. We noted that the registered manager was not in post when the staff member had been recruited for the position. Disclosure and Barring Service (DBS) checks had been carried out on all staff. The DBS carries out criminal record checks and helps employers make safer recruitment decisions. However we found where information on a DBS showed prior convictions there was no records to show that these had been discussed as part of the recruitment decision to ensure they did not pose a risk to people they were supporting. The registered manager explained they had not been part of the recruitment process at the time these decisions were made as it was before they were in post but agreed to follow this up with the head office.
This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff's identification, such as their passport had been signed and dated to show that the original documents had been seen, however there was no documentation in staff files to show that passports had been verified by the provider to evidence their authenticity and that staff had the right to work in the United Kingdom. The registered manager explained that this was actioned by the head office and after the inspection sent us the recruitment guidance to show that this was done.

People had mixed views about having enough staff to support them in the service. Their comments included, "Sometimes there is not always enough staff" and "Yes there is enough staff." Although some people were able to access the community independently they expressed the wish to be supported by staff. They said, "I can go out when I choose, but it would be nice for staff to accompany me sometimes" and "I am confident but I have not gone on an activity with staff outside, there's not enough to do that."

Staff rotas showed that there were three staff members including the registered manager that worked in the home during the morning and evening shift and on the days of our inspection we saw that the staff allocated on the rotas were on duty. Two members of staff told us there were enough staff but one said, "Enough staff? Well for me I always want more." The registered manager told us they were in the process of recruiting additional staff to provide floating support across the provider's three services and showed us the potential candidates CVs. They explained this would provide enough staff to accompany people in the community if they requested this.

Specific risks guidelines were recorded in people's files and included how to manage risks to their health, wellbeing and welfare and the associated triggers, moods and behaviours that may present as challenges to the provider. Staff we spoke with explained how they followed the guidelines to reduce the likelihood of risk to people and/or others. Records showed that external support had been sought to minimise risks following discussions with the community mental health team (CMHT) and statutory and non-statutory organisations, such as the Probation Service and the local authority. Risk guidelines were completed and reviewed as necessary, for example, following an incident or in response to changes in risk.

Clear guidance was in place to inform staff about how they should monitor and manage people's risks but in two cases we could not find any clear evidence recorded to show that guidelines were followed. For one person, records showed that they used aids to help them mobilise independently. Assessments included detailed guidance on how staff should manage the prevention of infection to reduce the risk of pressures sores. We found information to show how their mobility need was managed such as visits to health practitioners to check the person's skin integrity due to their dependence on the aids, but we could find no records to show how this was monitored by staff. Guidelines showed that this person at times refused

personal care, but there were no records to show how often the person refused personal care or when/how often the person's skin integrity had been checked by staff in between their health care visits.

For another person, whose behaviour challenged the service the provider had clear information about how staff should communicate with the person including avoidance techniques to be used to manage the person's behaviour. We found records to show that staff worked two to one with the person to mitigate further risks, however a health professional told us psychological intervention was not sought when this was advised and the records we looked at could not demonstrate when this was actioned by the provider. This meant that the provider had not done all that was possible to mitigate risks to individuals.

During the tour of the building we saw that all areas of the home were not clean and one person told us they had seen mice in the garden area. We checked the storage room at the end of the garden that contained stored foods, dried goods and a fridge and a large freezer. We found that the food items were stored appropriately but the fridge required cleaning. The registered manager explained that an external contractor had visited the premises as required to monitor pest control and the records we checked confirmed this.

In the communal kitchen we found that the extractor fan and tiles over the cooker were sticky with dried grease and the inside of kitchen cupboards required cleaning. In the communal hallway we observed that the carpets were unclean and worn and the bannister leading up to the stairway was unclean. Skirting boards, window ledges and pictures were dusty and windows had not been cleaned. The activity room was located in the rear of the communal garden and we observed there were used cigarette butts on the window ledge and general bric a brac. This meant that good infection control practices were not monitored to ensure that people who used the service lived in a clean and safe environment.

On the second day of our inspection we saw that the registered manager had addressed the cleanliness of the home with the staff team and posted a memo in the office to explain that all staff who worked on shift were accountable for the cleaning of the premises. We also saw staff cleaning areas of the home on both days of our inspection.

General maintenance was required in the home and the records that we checked evidenced that the provider had made requests for repairs to be made. We saw information to show that planned redecorations were to be completed in the home, to include internal painting to the communal areas and that new carpet was to be fitted on the communal stairway.

Cupboards that held Control of Substances Hazardous to Health (COSHH) items were kept locked and secure and maintenance and servicing of equipment was carried out. Fire tests and drills were recorded to demonstrate these had been completed regularly and people's file's held personal emergency evacuation plans (PEEPS) to ensure that people were able to evacuate the building in the event of an emergency.

We asked people if they felt safe living at the home and they told us, "Personally me, I feel safe here but that's because I'm very streetwise, I am out a lot" and "I like it here, it's safe enough, I just want to do the right thing." One relative told us their family member was safe in the home but not safe outside the home because of the area they lived in and other people they had got involved with in the community. We saw there was a plan in place to move this person into other accommodation. A second relative told us that their family member was not happy and wanted to move back home and when we spoke with their family member they told us this was because they wanted to move closer to their relative.

The staff we spoke with were able to tell us what abuse was and describe different types of abuse. They

explained that if they suspected people were at risk of harm they would report this to the registered manager or to an external body. Safeguarding procedures were in place to provide guidance to staff to ensure people were protected from harm. A health professional we spoke with told us they had sent the provider a copy of the correct safeguarding adult and children's procedures, therefore was confident they had the correct procedures in place.

Since the last inspection in May 2016 we had received no reported safeguarding concerns from the provider and the registered manager told us they understood their responsibilities in reporting safeguarding concerns in line with their procedures. There was a whistleblowing procedure to advise staff who they could contact if they witnessed wrong doings at work such as the NHS helpline, but the policy did not state that staff could also report workplace concerns to the Care Quality Commission (CQC).

There was a missing person's procedure in place. People's files held details of the relevant information staff could refer to and give to the police to identify the person if they went missing from the home; such as a photograph and physical description. The provider had notified us of incidents that occurred in the service, such as those involving the police and the actions they had taken. One relative commented, "They have phoned in an emergency when [my family member] has gone missing."

The missing person's procedure advised that staff must report a person missing to the police within 24 hours. A staff member commented, "If they are missing for 24 hours we have to notify the police within 24 hours, we call the police and get the CAD number." A CAD number is a Computer-Aided Dispatch (CAD) and is used to send a message to dispatch an emergency service to a particular location and can be used to store and retrieve data. We found that the provider had generally followed the missing person's procedure but on one occasion they had not. For example, in one instance we found that staff had not reported a person missing for 48 hours. This meant that the provider had failed to respond appropriately on this occasion to reduce the likelihood of harm to the person or others when they were missing from the home. We discussed this with the provider who acknowledged this and agreed to hold discussions with staff following the incident to further embed learning about the reasons why the procedure must be followed to ensure people's safety.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that written records of staff appraisals were completed but contained duplicate information in some staff records. During this inspection, before we viewed staff appraisals the registered manager duly informed us that the appraisals had not been fully completed and were due to be signed and actioned by them. We checked the appraisal records and found that staff had set their objectives to include what they would do, by when and how their performance would be measured. The records had been completed by the staff and contained different information about their development needs but we found that the registered manager had not added their feedback or signed the appraisals. They ensured us this would be completed in due course. We will check these during our next inspection.

The registered manager carried out supervision with staff regularly which included one to one discussions about their duties and responsibilities, training and conduct.

Staff had access to essential training to further develop their skills and knowledge. One member of staff explained how they kept up to date with their own learning and development needs. They said, "Staff have a duty of care to also train themselves, every resident has an involvement plan and different needs, we have to sit and read all the care plans. Any programme to do with health and social care I watch, I'm on the ball."

Records showed staff had received training in the provider's required mandatory learning which comprised of an induction, safeguarding, medicines, mental health awareness, infection control and the Mental Capacity Act 2005. A staff member spoke about the training that they had attended and commented, "I feel I have the ability and confidence to carry out my role."

Additionally, staff were supported with ongoing professional development, and a health practitioner explained that staff had access to specialist training facilitated by a multidisciplinary team, such as aspects of forensic training to further enhance their work practices. One member of staff described the training and told us this had been helpful in fully understanding people's symptoms and their mental health diagnosis. They commented, "We did a three day session with the psychologist and we went through all the mental health training and they gave us their email if we have any questions."

People gave us mixed feedback about the preparation, choice, and storage of foods. People told us they could access the communal kitchen to prepare snacks and drinks for themselves. Some people told us at times they purchased their own snacks and meals when they wished and one person commented, "I'm going to buy a blender to make smoothies." However one person told us that they wanted to store their own food items in the kitchen and not in their room and commented, "I used to buy my own food and put this in the kitchen cupboard but people ate my food." We saw that people did not have their own locked food cupboards in the kitchen to store their own purchased goods.

One person explained that the food did not cater for their cultural needs and commented, "I would like Caribbean food, I have been asking for this for months, don't let them tell you anything different." Records showed that the person had discussed this in a one to one meeting with a health and social care

professional and it was noted that they would like staff to cook more food to meet their cultural needs. Their care records showed the specific foods they enjoyed eating but we found these food items not recorded on the menu we checked over a period of four weeks.

A second person said, "Sometimes I just want a healthy dinner like a jacket potato and salad." Staff explained that people were asked for their feedback about their food preferences during residents' meetings, and were involved in the decisions about food choices. On the first day of the inspection we saw that oven chips and burgers were prepared, but not in a healthy way as we saw that the burgers were cooked in a frying pan full of oil. The second day we saw that the meal prepared was a healthier option of chilli con carne.

A third person told us, "We are not allowed sausages, meat is only allowed on the weekends. I am a vegetarian I don't care for meat but I want to speak for others, who may not tell [staff]. My needs are noodles sometimes I ask for eggs, the budget for food is short." We observed that meat was cooked during both days of our inspection and the freezer held frozen meat goods. Records showed that the person on occasion had eaten meat and when we informed the registered manager of this they explained that the person ate meat but the person told us this was because there was no other option but to eat meat. Menus showed the dishes that were served for breakfast, lunch, dinner and supper and it was noted that the lunchtime meal was of the person's choosing. Minutes of the residents meeting showed that discussions were held about the times meals were served and what foods people had requested but did not document which person chose the specific type of meals they preferred to eat. The menu we looked at did not show there were specific vegetarian dishes offered on the menu.

Three people told us they would like to cook their own food, but were unable to do this. They commented, "They have to cook it for us they want us to be independent living and they won't let us cook", "I want to cook my own food" and "They said I can't cook because I will set the smoke alarms off." A relative commented, "[The person] used to get takeaways but does not go out as much. I think it's about having enough staff around to support [him/her] in the kitchen to cook, now [they] are not getting takeaways as much."

Care plans recorded people's food preferences and their dislikes and the reason why people should be supported with healthy meal options, for example, to follow a diabetic plan. During the inspection we saw that the dishes on the menu were being served and we observed throughout the day people preparing, cereals, snacks and drinks. We observed that when people made requests this was acted on. We saw that one person was supported by staff when they requested help to make their breakfast. We asked a member of staff if people cooked their own food and they told us "not always". An assessment of people's needs showed that people were to develop culinary skills, but records such as one to one key work notes did not demonstrate where people were supported to prepare meals to increase these skills. We recommend that the provider seeks and acts on people's views about their mealtime experiences to ensure that their individual needs are met.

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.

We found that although best interests meetings were held in relation to specific decisions about people's health, welfare and financial matters areas of the home had restricted access. People's consent had not

been sought about this and people were not informed why these areas were kept locked or about when they could have access to these rooms. During the first day of our inspection we noted that the activity room that contained a pool table was locked. The registered manager told us this should always be open but said staff had to monitor that this room was not used as a smoking area.

The lounge area had a television and computer and one person commented, "The computer might work but I don't need to use it I have my own." However we observed that on both days of the inspection the door to access the lounge was kept locked. Staff told us this was locked due to an incident that occurred in the lounge; however there was no information to inform people why this door was kept locked or when they could use the lounge and people's consent had not been sought. The registered manager agreed to place a notice on the door to inform people that they could access the lounge if they wanted to, however this was not ideal and did not support a homely environment where people could freely access communal areas. We recommend that the provider seeks advice from a reputable source about their responsibilities under the MCA and restricting access to communal areas.

Consent forms had been signed by some people regarding the retention of their care records and to agree that their records would be archived and held at the head office, but we noted the forms did not indicate how long the records would be retained for. For one person records showed they had signed a consent from to agree that staff could purchase a particular item for them and we saw that this person came to the office to collect this item. The provider had sought permission from people to use their photographs to put on their files, and for one person an easy read version of this form was used to ensure their understanding of what the provider had requested.

For one person their records showed the decision making process around the management of their finances. This included notes and detailed discussions with the appropriate parties such as seeking support through the use of an appointee, an Independent Mental Capacity Advocate (IMCA) and the local authority. This demonstrated that the provider fully explored all areas of support before forming a balanced view about a specific decision in relation to the person's care whilst protecting their rights.

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). Following guidance the registered manager had made a referral to the local authority for a DoLS assessment to take place for one person. A visiting professional explained the circumstances that led to a best interests meeting being held to discuss the most effective option to ensure that the restrictions being considered for the person were appropriate.

People told us they had access to healthcare services. One relative commented, "[My family member] has to go for regular blood tests for their medicines." Records demonstrated that the provider liaised with healthcare practitioners to discuss their health matters and made certain that intervention was sought to quickly to mitigate any risks associated with people's health care needs. For example, one person had a history of non-attendance at health appointments so staff had arranged for their GP to visit them at home to monitor this. Discussions about people's compliance with their medicines, behaviours and mental health were documented in their records during their meetings with a number health and social care professionals. This was to establish people's progress and well-being and to obtain feedback on how the provider was meeting their needs.

Care records identified how people's healthcare needs were managed by clinicians such as community mental health nurses and psychiatrists. Care plan approach meetings (CPAs) were held to establish people's progress and overall well-being and to review the support they received from multi-disciplinary agencies.

Although attendance at appointments was noted in people's daily records and the diary, we found that separate records held for health action plans generally only covered one aspect of people's health care needs and provided a very brief description of that need. This did not take into account the overall assessment of people's health needs and we found that one person's plan required a review. The health professionals we spoke with told us that staff frequently communicated with them to seek advice, for example, if they observed any changes such as the deterioration in people's mental health or disengagement from services.

Good

Is the service caring?

Our findings

The majority of people told us that staff were caring and they commented, "They help, I think they care", "At times not bad" and "They are alright, they care." However one person disagreed and said, "They operate like we are still in hospital, we are adults, not kids, they talk down to us." People's relatives spoke of the caring nature that staff displayed and commented, "They are really caring especially [staff name] they try their very best" and "I can't complain about the staff. [Name of staff] did a barbeque in the garden for them, [my family member] is not easy to manage."

One person told us they felt the house rules were too structured and said, "They don't allow us to have visitors they have us on a structure they come in and sign. They should at least allow visitors, my family and friends have to wait outside." People were provided with an induction to the service that told them what to expect and explained their responsibilities when they first moved into the home. This included the aims and objectives of the service, expectations of living in the home and relevant contact details. There were house rules that people had to follow whilst using the service. People had to seek the permission of staff before inviting visitors to the home to ensure people's protection and people had signed records to show they had read and understood the reason(s) for this. The service manager told us at the time of the inspection no one in the home was currently subject to a curfew and held discussions with people about arriving back at the service at a reasonable time for their safety.

We observed that people approached staff comfortably when they asked for support and that this was given. We saw that staff spoke with people in a calm and respectful manner and they greeted people when they saw them in the home. People were given space to get on with their daily routines and we saw people going out and returning to the home throughout the day. During the course of the morning one person returned to the service and gave staff a local newspaper to read, the staff member responded, "Thank you, that's very kind of you." In one instance we heard a person become distressed, anxious, and verbally berating a member of staff before taking their medicines. The staff member calmly explained the importance of taking their medicines and the reason for this. The person apologised for raising their voice and the member of staff graciously accepted the apology.

There were spacious communal areas, such as the garden, lounge and kitchen. We observed that people interacted with each other in the communal dining area. We saw during different times of the day that people used this area frequently and used the facilities to make hot drinks, or relax in the dining area and exchange conversations with each other. There were large patio doors that led out onto the garden and we saw that people used this area to smoke or sit quietly with their cup of coffee or tea. We observed one person tidying the garden with a member of staff and the person commented, "I like to keep the place clean, I like doing it." We saw later that this person's room was neat and orderly.

Relatives we spoke with told us they were able to visit the home when they wanted and frequently spoke with staff over the phone, who gave them feedback about their family member's well-being, if people had agreed to this. They said, "Staff they do keep in contact, I know the key worker very well who keeps me updated" and "The staff do keep in contact and pass on messages for me when [my family member] is not

in."

People told us their privacy was respected and they commented, "They always knock before they come into my room" and "Yeah they knock, they have to."

Room checks were carried out by staff and notices were displayed to underpin this and inform people that this was done to check the safety of their rooms in accordance the provider's health and safety procedures and people had signed to consent to this. People had their own keys to their rooms and told us that if they needed their own private space they would use their rooms when they needed to enjoy their space, relax or seek solace. Three people gave us permission to view their rooms. We saw that people accessed their rooms with their own key and staff waited for permission before they entered their rooms. People's rooms were furnished with their personal belongings and items that were important to them.

People's confidential records were stored securely on the premises and we noted that when the registered manager spoke with us about the care and support people received they closed the office door so the conversation could not be overheard. There was a separate meeting room in the home where people could talk and meet with staff and discuss any private matters.

The staff we spoke with told us the reasons why they enjoyed working in the home and spoke positively about the workplace and encouragingly about the people they supported. They commented, "It's definitely not the money that keeps me here it's the personal rewards you get from it", "I am willing to do what they need if I can help" and "I have been here about a year and I love it. I have a passion for care, not only in mental health but learning; and you know, just contributing for my own equilibrium."

Requires Improvement

Is the service responsive?

Our findings

People's individual needs were not always fully met. People were allocated keyworkers to provide one to one support and arrange monthly meetings to discuss the support they needed to reach their chosen goals and outcomes as detailed in their care plans. One person commented, "They support me with medical appointments and if I have difficulty getting benefits."

We checked a sample of the one to one meeting notes and found they did not fully demonstrate how people were supported in these meetings. Key work notes did not provide sufficient detail to demonstrate that people were receiving personalised care. They did not contain comprehensive notes but a briefly written sentence about what the person had done that month. Records for three people contained the same information about the person's goal for several meetings. For example one person's records in August 2017 showed that staff had written 'extended service attempt to register with [health service] and enjoys going for a walk' but this remained the same as written for June 2017 and May 2017. For another person's records it was written, 'attends the day centre is independent and play cards.' This also remained the same for subsequent meetings. The records for key work meetings failed to demonstrate how people's individual needs were considered and how people were supported to work towards their goals. Therefore, we could not be assured that people's individual needs and preferences were being met.

People spoke with us about the interests and hobbies they were involved with independent of staff. However one person commented, "Because we have mental health needs we used to go out on day trips. They stopped all that when we asked for support." And a relative said, "All I know is that [person's name] sits in [their] room a lot and has too much time to think. [The person] used to be a fantastic artist, used to be so good but does not do this anymore. I think [my family member] needs to get [their] confidence back."

We looked at the service user contract that people had signed which advised that assertive and relaxation activities would be offered, that holidays would take place once a year and that outings would take place to other places of interest. We saw during the first day of our inspection that people came and went as they chose and on two occasions we saw that a staff member supported a person to go to the dentist and another person to the shops. We saw records to show that people had access and had been referred to external workshops, day centres and healthcare facilities. Contact sheets were designed for staff to record people's mental state, work and play and participation in therapeutic activities. We saw again that these notes were not comprehensive. Although the majority of people were independent we did not see clear records to show what assertive and relaxation activities were offered by the service, such as activities in or outside the home. The registered manger showed us information on how they were supporting one person in the service with their employment and training skills and told us there were plans to take people out on a planned holiday and trips. However, these activities were not taking place at the time of our inspection. Therefore we could not be assured that the provider was meeting people's social and leisure needs.

The above issues relate to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' records reflected the things they liked to participate in, such as local outings, music, and exercise. One person had certificates of education they had obtained before moving to the service and proudly showed us these as a mark of their achievements. A second person showed us the TV they had bought in their room and told us of their plan to purchase new surround sound speakers for this. A third person told us about their interest in music and allowed us to listen to the music they had made on their hand held cassette. On the second day of the inspection we saw that one person was dressed in their football kit, they told us they were going to play football and said they played regularly.

People told us that they knew how to complain if they were dissatisfied with the service and would speak with the staff but some people told us they did not like to put their complaint in writing. They commented, "I would just speak with my keyworker if I wanted to complain", "It's on the board, it tells you how to complain, but I'm not putting it in writing", "I have no complaints" and "My views are not listened to most of the time, I get told to write a complaint, I have never been to a residents meeting for this reason." A staff member told us, "The residents can voice any concerns that they have."

The provider's complaints policy stated that if people had a complaint they may be asked to formally put their complaint in writing and their concerns would be investigated and acted on within a specified timescale. The registered manager told us they had received no written complaints since the last inspection; however they did not keep a record of or take into account informal complaints to demonstrate that people were listened to and to ensure that any concerns were addressed and improvements made to the service.

We reviewed the complaints policy however the information in this was inaccurate. The policy documented that people could approach the CQC if they were not satisfied with the provider's response to their complaint, however the CQC do not investigate complaints directly. The policy did not provide further details of other external organisations people could escalate their complaints to such as the NHS and the Local Government Ombudsman (LGO). We recommend that the provider reviews their system for managing complaints to ensure that it is accessible and takes into account all concerns raised by people using the service and demonstrates how complaints have been resolved.

Initial assessments had been carried out to ensure that people's needs could be met. Care plans outlined people's circumstances, recreational pursuits, lifestyle choices and health needs and the relevant contact details of those involved with their care.

Guidelines drafted by health professionals contained further supplementary information about the way that staff should reinforce messages and manage people's specific needs. Records showed how staff should communicate with people such as, tone of voice, reasoning and understanding, what to do if the person became distressed. Staff told us about people's background and circumstances before we were introduced to them and gave us an overview of their diagnosis. For one person, guidance showed they enjoyed playing dominoes and used humour to communicate but did not like to lose. We observed staff playing cards with the person and when we asked who was winning the person smiled and responded, "I am."

Some people were required to meet conditions as part of their recovery and reintegration into the community before they moved into the home. There were opportunities and support available to promote people's autonomy and independence. Referrals were made to the appropriate services to ensure people had access to support, advice, voluntary work placements and educational facilities to meet their diverse needs. One person told us they attended a mental health drop in centre once a week that offered different activities they could partake in and seek advice if this was needed and records showed that the centre they visited specifically met their cultural needs.

Records showed people were offered professional intervention to support them with their physical and mental health needs including substance misuse. Where one person did not engage with their programme of support we found they had received a letter from their mental health caseworker about the requirement to engage with this.

The provider worked with the CMHT to ensure there were pathways for people moving on from the service. There was information to show there was a process to move two people on from the service and records showed one person was in the transition to step down into more independent accommodation. For a second person they explained they wanted to move to an area that was closer to their relatives and a health professional we spoke with confirmed they were working with the person about their future accommodation needs. A third person who had lived in the home for a number of years told us they were keen to move on and said, "I really would like a different place to live. I want my own privacy and space, there are too many police and at night it gets loud." A health professional told us about the person's circumstances that currently prevented them from moving to another service and did not rule out a future placement being sought for the person.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were not robust as they had failed to detect the issues that we identified during our inspection. We found that the provider's audits were not carried out consistently and rigorously and had not identified issues in relation to medicines, recruitment, infection control, care records, staff appraisals and staff working hours. People's views about their nutrition and complaints had not been fully considered to ensure that people's experiences were understood and to inform improvements. Restrictions were placed in certain areas of the home and there was no information to show that people had been informed about the reasons for this or given their consent. This meant that systems were not effectively monitored to improve the quality and safety of the services provided to people.

There were systems in place to seek people's views and overall satisfaction with the service, which included surveys and residents meetings. We checked the results of the surveys and found that people were generally satisfied with the service, however three people had commented on their dissatisfaction with the food and leisure arrangements, cleanliness of the home and their medicines. These responses had not been evaluated to obtain further feedback from people about these matters to improve the effectiveness of the service. The registered manager agreed to act on this to further seek people's views and address these issues some of which were identified during our inspection.

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

Minutes of the residents meetings showed they were used to discuss matters affecting the service. The provider showed us records to demonstrate that the neighbourhood police and safer neighbourhood team had attended one of the meetings to talk to people about how to keep safe from harm and one person spoke with us about their attendance at this meeting. This showed that the provider worked with in partnership with external agencies to reinforce messages about people's safety in the service and the community.

We asked people if they thought the service was well led. People told us, "I really don't know, I know my keyworker is good", "Other's know this place better than me but [registered manager] is good and helps", "No I don't" and, "We all go through things together, it's good." People's relatives commented, "My opinion is that they are good I think they work well together" and another said that staff were, "Helpful, available and accessible."

At the last inspection there was no registered manager in post. During this inspection there was a registered manager who had been in post since October 2016 and was further supported by a deputy manager in their absence. They explained they were committed to making changes and improvements to the service and we observed they were on hand to support people and staff during both days of our inspection. They were proactive in addressing and responding to any issues brought up during the inspection and told us they were committed to making improvements at the service.

Staff spoke positively about the registered manager and told us they felt confident about speaking with him about any concerns they had. Their comments included, "He is doing well, I can vouch for him" and "I can ask my manager if I have any problems, I can go to him for anything." Staff meetings took place so that staff could discuss people's well-being, voice their opinions and make suggestions about improvements to the service. We listened to a handover meeting between staff before they changed shifts and during the meeting they discussed observations of people's moods, who staff had interacted with during their shift, medicines, the times people arrived and left the home, their health appointments and nutrition.

We noted that all the people in the service were supported by same gender staff and we asked if people requested to be supported by staff of the opposite gender how this would be met. The registered manager explained that during the provider's recruitment drive they would be recruiting more staff including those of the opposite gender. This information was also noted in the provider's business plan along with others areas of planned improvement for the service. This included managing change, staff retention, staffing hours and recruitment of staff to provide more support for people in the community.

The provider maintained good working relationships with external stakeholders to ensure there was a planned approach to supporting people to maintain their independence as far as practically possible. They had received written compliments about the service and about the care people were provided with. A health practitioner had written, 'A very good care setting, the service is adequate and I work well with the staff' and a relative had written 'I am happy with the service'.

The provider is required by law to notify CQC of incidents that occur in the service and we had been informed of these as required.

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 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not met: The registered person did not ensure that the care of service users was appropriate, meet their needs and reflected their preferences to demonstrate that care was appropriate to meet their assessed needs and wishes. Regulation 9(1)(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate any risks and did not ensure the proper and safe management of medicines Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Good governance on systems or processes were not established and operated effectively to

ensure compliance to assess, monitor and improve the quality and safety of the services provided and did not maintain an accurate, complete and contemporaneous record in respect of each service user Regulation 17 (1) (2) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not met: The provider had not ensured that all information specified in Schedule 3 was available in respect of each person employed Regulation 19 (1)(3)(a)