Covenant Care Support LLP

Covenant Care - The Wheelhouse

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service: The Wheelhouse is registered to provide care and support to a maximum of 10 people with a learning disability or who are living with autism, mental health difficulties, physical difficulties and/or sensory impairment. The service is also registered to provide personal care to people who live in their five supported living houses. At the time of the inspection nine people were living at The Wheelhouse and 19 people were being supported by the supported living service.

There were aspects of the service that did not meet the values that underpin the Registering the Right Support and other best practice guidance. The values set out in the Registering the Right Support include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Although there was evidence the service was promoting community access, some independence and inclusion, there were aspects which did not demonstrate people made choices and have autonomy over their lives.

People's experience of using this service:

At our last inspection in July 2016 we identified the quality monitoring systems were not fully effective because they were not identifying care plan reviews had not been carried out. During this inspection we found the quality monitoring systems had not improved and were still ineffective at The Wheelhouse. The systems in place had not identified all of the concerns identified during this inspection.

People were not always protected from harm. Potential safeguarding incidents for people living in the Wheelhouse were not always reported to the local authority safeguarding team. The registered manager at the Wheelhouse was not fully aware of their responsibility to report safeguarding concerns. There were no safeguarding concerns identified at the supported living service.

The registered manager at The Wheelhouse was not aware of their responsibility to notify the Care Quality Commission (CQC) of significant events in line with their legal responsibility. The provider had failed to ensure there was sufficient oversight and governance at the service.

Risks were not always being fully managed at The Wheelhouse, and they were not always managed in a way that promoted people's freedom, choice and control. There were risk assessments in place in relation to aspects of people's care in both services.

Incidents and accidents were recorded by staff and reviewed by the registered managers. The registered manager at The Wheelhouse was not analysing incidents for themes and trends that might identify factors to prevent future incidents.

Some areas of The Wheelhouse were not clean on the first day of the inspection. We did not identify any concerns relating to cleanliness at the supported living service. There were enough staff to meet people's

needs and staff were recruited safely. People's medicines were managed safely.

People's rights were not fully protected because the correct procedures were not always followed when people lacked the capacity to make decisions for themselves at The Wheelhouse.

Some areas of The Wheelhouse were in need of updating and refurbishing. The provider had a refurbishment plan in place to address this.

Staff raised concerns about some people not always getting on at mealtimes in The Wheelhouse. The registered manager put a plan in place to address this.

People were encouraged to make food choices during a monthly review about their care. There was a good balance of different foods available to people. People were supported to access a range of healthcare professionals.

Staff received appropriate training to meet the needs of people. Staff said they felt supported by the registered managers and they received regular one to one supervision.

Interactions between people and staff at The Wheelhouse did not always demonstrate dignity, privacy and respect. Some of our observations of staff interactions at the Wheelhouse were positive. People were supported to maintain contacts with family and friends.

We saw example's where people's care was responsive to their needs and preferences and some areas where it was not.

Relatives commented positively about the staff team and support their family members received, they said they could visit anytime and were always made to feel welcome.

There was a complaints procedure in place. Where a complaint had been raised, this was responded to and actions implemented. Relatives felt confident any concerns they had would be addressed.

People's feedback was recorded monthly during a one to one meeting with them. Relatives felt they were involved in their family members care.

Staff felt supported and involved. The service worked in partnership with other organisations to support care provision.

The provider listened to the feedback provided during the inspection and responded by taking immediate action and providing us with reassurances they would make improvements where required. They send us information relating to the actions they had/were taking.

We have made two recommendations, one in relation to infection control and one relating to following our publish guidance relating to submitting statutory notifications.

Rating at last inspection: Good (Report published August 2016)

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: We found three 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.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Requires Improvement

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

Covenant Care - The Wheelhouse

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 one inspector and an expert by experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had cared for a person living with a learning disability. The second day of the inspection was carried out by two inspectors.

Service and service type: The service is a residential home. In addition, the service provides personal care to people who live in their own home.

The service had two managers who were registered with the Care Quality Commission. One was registered for The Wheelhouse and one for the supported living service. 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 first day of the inspection was unannounced. We arranged the date of a second visit during the first day of inspection.

Inspection site visit activity started on 25 March 2019 and ended on 28 March 2019. We visited people living in the supported living accommodation on 28 March 2019.

What we did: Prior to the inspection the provider completed a Provider Information Return (PIR). This is a

form that asks the provider to give some key information about the service, tell us what the service does well and the improvements they planned to make. We also reviewed information we had received about the service since the last inspection in July 2016. This included details about incidents the provider must notify us about. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

People living at The Wheelhouse were unable to tell us about their experience of living there. We therefore used a number of different methods to find out what life was like for them. This included undertaking observations of the interactions between people and staff and speaking to people's relatives.
Some people in the supported living accommodation could tell us their experience. However, they were not available on the day of our visit, although we had arranged this visit in advance.

During the inspection we were able to observe all of the people living at The Wheelhouse. We saw people living in the supported living accommodation but were unable to speak with them as they were going out to a planned activity. We spoke with nine members of staff, two registered managers and met the provider. We reviewed three people's care and support records, three staff files, and sampled medicine records. We also looked at records relating to the management of the service such as meeting minutes, policies and audits. We sought feedback from professionals who work with the service. Following the inspection, we spoke with two further relatives.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding procedures were in place. However, these were not always followed by the registered manager of The Wheelhouse to ensure the appropriate investigations and reporting processes were completed. For example, we found incidents where two people had unexplained bruises. Staff had recorded this on a body map and the registered manager had reviewed these. However, they had not all been investigated and reported to the local safeguarding team. The registered manager confirmed following the inspection they had reported these to the local authority. We also raised a safeguarding alert following the inspection.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

- Staff understood how to report concerns which might indicate abuse. We saw that safeguarding had been included in a multi-subject on the staff induction. Which meant they had received training in the subject.
- However, during our inspection a safeguarding allegation was disclosed to the inspector and had not been reported in line with the providers whistleblowing policy. We therefore raised an alert with the Local Authority safeguarding adults team. They will investigate in accordance with their own protocols. Their findings are not part of this report.
- No safeguarding concerns were identified at the supported living service.
- Following the inspection, the provider provided evidence they were putting actions in place to safeguard people.
- Relatives told us they had no concerns regarding their family members safety.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks were not always being fully managed. We saw cleaning chemicals left unattended in a toilet that was accessible from inside one person's apartment, the door was seen as open on one occasion and unlocked on another. Cleaning chemicals were also seen in an open cupboard under the kitchen sink. Although people received one to one staffing support, by cleaning chemicals being accessible this increased the potential for there to be an incident, should a person who did not understand the risk have unattended access those chemicals. The registered manager confirmed there had been no incidents involving cleaning chemicals and confirmed they would ensure these were locked away.
- The Wheelhouse's approach to managing risk and minimising restrictions on people's freedom, choice and control needed to be improved. Whilst we found some examples where risks had been assessed and mitigated, for example using a water boiler rather than a kettle which enabled a person to access the kitchen. There were other areas of risk where the approach had been to restrict people rather than looking

at lesser restrictive options.
● People living at the Wheelhouse and being supported by the supported living service had risk assessments as part of other aspects of their care planning. These covered areas such as; accessing the community, accessing areas of the home and medicines. The risk assessments included management plans to reduce the likelihood of the identified risk.
● Environmental risk was also assessed. For example, there were some low beams covered with foam, so people would not hurt their head.
● Equipment, the service's vehicles and the environment were regularly checked. Servicing and maintenance ensured the premises were in a safe state.
● All accidents and incidents were recorded and reviewed by the registered managers.
● People had detailed care plans in place to guide staff on how to support them during times when they were anxious. The plan included details of what made the person anxious and how staff should respond at these times.
● Staff told us incidents at The Wheelhouse were manageable and they said they didn't use any form of restraint.
● The registered manager at The Wheelhouse was not currently analysing incidents for themes and trends that might identify factors to prevent future incidents.

Preventing and controlling infection
● We found on the first day of the inspection, areas of The Wheelhouse were not clean. This included the underside of tablecloths, bedroom floors, and some surfaces were sticky to the touch. The floor in the dining room was also sticky. Toilet bowls were stained. The registered manager explained that it was considered unsafe to use bleach in The Wheelhouse and how difficult it was to maintain a clean service due to some people's actions, such as destroying fittings and furnishings.
● Cleaning was included in the support staff role. The registered manager told us that night staff did some cleaning, day staff did some cleaning and staff did a "deep clean" at weekends. Staff said it was not always easy to support people and undertake laundry, and cleaning. During the morning we noticed that staff were cleaning the home. One staff was cleaning the floor with a dust pan and brush and another was cleaning the TV cover. The Wheelhouse was cleaner on the second day of the inspection.
● The laundry room was very small but included equipment which would be suitable to use for soiled laundry. Although there was a basin in the room, there was no soap or towels. The provider told us these were usually kept topped up. A staff member said they used the kitchen basin to wash their hands, the provider confirmed staff would use the second hand washing sink. This however, would pose a risk of cross contamination. Following the inspection, the provider confirmed they had moved the laundry sink to make it more accessible to staff.

We recommend that the provider refers to current national guidance and best practice to prevent the spread of infection

● Staff had access to appropriate personal protective equipment, such as gloves and aprons, and bags for soiled laundry.
● We did not identify any areas of concerns relating to infection control at the supported living service, which was very clean and fresh.

Staffing and recruitment
● Staff opinion of the staffing arrangements were mixed. Some staff commented there were enough and others thought there were shortfalls. Staff confirmed the registered manager helped out when needed.
● Relatives told us they thought there were enough staff available, they said there had been some changes

in staff but it had not impacted on their family members care.
● People had allocated individual hours at The Wheelhouse. The provider confirmed how the staffing arrangements were set up to meet people's individual needs. Staffing rotas confirmed this.
● The registered manager confirmed bank staff and agency staff were used to cover staffing shortfalls and the service they were currently recruiting additional support staff.
● The registered manager at The Wheelhouse told us staffing deployment had been recently reviewed.
● Suitable recruitment checks were completed before new staff worked with people. Those checks provided information from which the registered provider could make safe recruitment decisions.

Using medicines safely
● No person within The Wheelhouse, or the supported living accommodation we visited, had been assessed to manage their own medicines safely, and so staff did this for them.
● Medicines within The Wheelhouse were stored in line with good practice guidance. At the supported living accommodation, the temperature of the storage area was not monitored, which had the potential for medicines to be stored above the manufacturer's recommended temperatures. The registered manager said they would instigate temperature monitoring to prevent this.
● At The Wheelhouse there were protocols in place where any medicine was administered 'as required'. This had not yet been instigated at the supported living accommodation. We were told this was because the medicine was only recently prescribed and had not been needed. Clear protocols helped staff consistency when making a decision whether to administer a medicine or not. It was the providers policy that a senior staff member should be involved in that decision.
● Good practice in medicine management included clear record keeping, orderly storage, monitoring the use of medicines, using codes when a medicine was not administered and two staff check hand written entries.
● A pharmacist inspection visit in 2018 had made some recommendations, which had been followed up appropriately.

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

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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes 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.
● People's rights were not fully protected at The Wheelhouse because the correct procedures had not always been followed where people lacked capacity to make decisions for themselves. We found restrictions were placed on people and the registered manager told us there were no capacity assessment completed or best interest decisions. Following the inspection, the provider submitted capacity assessments, however these did not meet the principles of the MCA.
● For example, some people had restricted access to water in bathrooms, toilet roll, food, drinks, clothes, bedding, toiletries, the kitchen, TV remotes and for some people toilet seats. Staff and the registered manager told us these practices were historical and had been implemented to protect people, the environment and their belongings.
● There was no evidence of the restrictions being regularly reviewed. This meant people were at risk of receiving care and treatment which was not in their best interests or in line with statutory guidance. We spoke with the registered manager who told us they would review their processes for assessing people's capacity in line with the Mental Capacity Act 2005.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

● We found some evidence of the MCA being followed relating to decisions being made for people. For example, people's finances and consent to treatment.
● DoLS applications had been made as required, the registered manager had contacted local authorities to enquire the progress of the DoLS applications. Three DoLS applications had been granted.
● We did not identify any areas of concerns relating to the MCA at the supported living service.

Adapting service, design, decoration to meet people's needs

● Some areas of The Wheelhouse were in need of updating and refurbishing. For example, some of the bathrooms and people's bedroom furniture was worn. The registered manager told us the provider had started updating areas of the home, and we saw evidence of this during the inspection. They also told us there were plans in place to further improve the environment and the provider forwarded the plans to us following the inspection.

● We saw one person's bedroom that had been personalised and decorated with their personal items and had blinds because the person preferred to have their room dark.

● The inside communal space consisted of one lounge and a kitchen and dining room for six people. The kitchen and dining room were locked when staff were not present. The environment was not arranged to meet the needs of people in a therapeutic way.

● People, however, enjoyed using the safe, attractive garden area, which included a swing, gazebo and plants.

● A health care professional said, "(I have seen that) there have been some improvements made to the actual environment and these improvements are ongoing."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's care plans had been designed based on people's individual needs. Care plans included specific outcomes for the person.

● Staff raised concerns about some people not getting on in The Wheelhouse. One staff member said about mealtimes, "[Name] and [name] don't get on, [name] is intimidated by them." We saw one instance during lunchtime where one person had to wait until the other people living in the home had finished their meal. We were told this was due to the person needing to eat on their own as they would grab at other people's food. Waiting for their meal appeared to cause them some anxiety. We discussed with the registered manager and they confirmed some people could become anxious over a noisy and busy environment. Following the inspection, the registered manager confirmed they had developed guidance around mealtimes that provided people with a more relaxed mealtime experience, with them having more choice and control.

● The service manager described how they were supporting people in the supported living service to get along and live together, they said this was proving successful.

Supporting people to eat and drink enough to maintain a balanced diet

● People were unable to comment about the food but one person said how much they liked chicken curry. That was the main meal that day.

● Both days the main meal at The Wheelhouse was attractively presented and smelt very appetising and we saw different options were prepared to meet people's needs and preferences.

● People were encouraged to make food choices during a monthly review about their care.

There was a good balance of different foods available to people. The registered manager at The Wheelhouse said all food was home-cooked.

● People were encouraged to eat a healthy diet. Where required, people were given additional food, such as rice pudding at 10am for a person who did not eat much breakfast.

● People enjoyed eating out and were supported to do this.

● Dietary concerns were followed up with appropriate health care professionals.

Staff support: induction, training, skills and experience

● Staff were mostly positive about the training they received. Their comments included, "Brilliant. I've done loads, including at Bridgwater college. (The registered manager) offers lots and it is always mentioned in supervision."

● Staff received an induction when they began at the service. This included orientation to the service and shadowing a more experienced staff member for as long as necessary. One staff member was signed up to start the Care Certificate. This is an identified set of induction standards that health and social care workers should adhere to when performing their roles.
● We saw that a staff member employed in December 2018 had a 'Training and Development' portfolio. This included a lot of information, which had been covered on the one day, in December 2018. The staff member was not sure if they had covered some subjects, such as safeguarding, but we saw that this was included in that day's induction. The staff member said, "(The induction) gave me an insight into what was what bit it was a bit education overload to be honest." Following the inspection, the provider confirmed they had reviewed their induction process to address this.
● Staff received training which included training in conditions relevant to people's health care needs. Examples included, autism, managing behaviour that may challenge, epilepsy and swallowing difficulties. However, our observations of staff managing people's anxieties at The Wheelhouse were mixed. We discussed this with the registered manager who told us they would support the staff to increase their skills in this area.
● Staff said they were encouraged to progress in their career.
● Staff received regular supervisions and appraisals, to support them to deliver care to the expected standard. One said, "At supervision you can air anything that is on your mind and they listen."
● Staff said they felt fully supported. They said they could take any query to the registered managers.

Staff working with other agencies to provide consistent, effective, timely care
● A health care professional said, "The people living (at The Wheelhouse) are supported appropriately with all of their needs being met effectively and in a person-centred way."
● Records showed that people's health was supported by regular checks ups and treatment, for oral care and foot care, for example.
● The registered manager at The Wheelhouse had identified that one person would benefit from an occupational health assessment. To date they had been unable to get this appointment but said they would keep trying.
● Staff had acted quickly to resuscitate a person who had collapsed.

Supporting people to live healthier lives, access healthcare services and support
● One person's family member told us their family member's weight fluctuated. They said, "Staff always keep an eye on her weight."
● People had hospital passports in place, which would provide information to health care services about the person should they be admitted to hospital. Staff described how they supported one person who had anxieties about visiting the hospital to attend a hospital appointment for an operation. They described this as being successful.
● People were supported to access a range of healthcare professional such as their GP, opticians, chiropodists and dentists.
● We saw evidence of health professionals commenting positively about the support the supported living staff gave to people regarding their health condition. One positive comment was received from hospital staff regarding the knowledge and organisation of staff during a hospital visit.

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

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

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity at The Wheelhouse and supported living accommodation was not always upheld.
- In one person's records it said, "(The person) was well behaved." We also heard a staff member say to one person, "Good girl." A third interaction included a staff member saying, "You won't be able to go out if you are silly." Which indicated that these people were considered to be like infants. The provider told us this was the preferred way of staff communicating with people, however this was not documented in their care plans.

- Staff made reference to one person needing a pad change in front of others, which was undignified for the person involved. The provider told us this was the preferred way of communicating to the person their continence requirements, however this was not detailed in their care plan.
- In one person's care plan it was identified staff should try and avoid anxieties by; "Trying to avoid waiting, never saying no and offering a drink." Records demonstrated this approach had not been followed by one staff member despite clear guidance being implemented by the registered manager following an incident, which resulted in a further incident.

- The registered manager at The Wheelhouse and the provider told us they would address all of the concerns we identified.
- We received evidence of staff supporting people to be independent in the supported living service. This included supporting people to be independent with their continence needs.
- Relatives described the staff team as, "Kind, patient, helpful and thoughtful."
- One relative commented on how staff always showed an interest in their family member's past. Commenting, "They are interested in (name) and talk to us about their past."

Ensuring people are well treated and supported; respecting equality and diversity

- Some staff engagement with people at The Wheelhouse was very positive. For example, staff were seen holding one person's hand and talking to them. They played a game of clap-hands with the person and they found this amusing. The staff then said, "Let's go for a walk my darling."
- A health care professional said, "I have found both management and the staff team to be very welcoming and caring and this has been reiterated when speaking to family members." One relative told us, "It's a pleasure for us to visit, I've always got on well with them."
- People were supported to maintain contacts with family and friends. For example, one person attending a family wedding.

● The registered manager at The Wheelhouse said there were policies in place with regard to equality and diversity. Staff were very clear that people's individual needs were understood and met. One person had historically liked to attend church, but then changed their mind. Staff knew that they still enjoyed listening to hymns.
● Relatives thought their family members were treated with dignity and respect. One relative said, "Definitely, yes they are very good at that."
● Staff had supported a person in the supported living service to hold an "Elvis" themed birthday party. After the party the person was reported to have said, "I've had a best day."
● We saw compliments from the supported living service reporting on staff being kind and helpful. A relative had commented on how their family members appearance was, "Fab" and they wanted to thank all of the staff.

Supporting people to express their views and be involved in making decisions about their care
● The registered manager at The Wheelhouse expressed the difficulty they had in ascertaining some people's views, this was because of their communication needs. In response to this they had produced person centred pictorial question booklets. This helped people to make decisions based on recognising what options were available.
● Some decisions, however, had been made for people living at The Wheelhouse without considering their preferences. For example, decisions around certain belongings being locked away such as clothing, bedding and toiletries.
● Staff described how they offered people day to day choices relating to activities, clothes, meals and drinks.

● At the supported living service, people were involved in their care planning and supported to express their views.

Requires Improvement

Is the service responsive?

Our findings

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

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

● Some improvements were needed to ensure people's individual communication needs were assessed, met and recorded in line with the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with a disability, impairment or sensory loss.

● People had communication needs that were identified in their care plans. We saw examples of people's communication needs being met. For example, one person used a 'now and next' board so that staff could support them to make decisions of what was happening throughout the day.

● However, there were other examples where communication could be improved. For example, the communal communication board in the hallway contained days of the week and a range of symbols that were not arranged in an organised and meaningful way. The symbols included TV, cleaning, walk, garden centre, coffee, drive and arts and craft. We discussed this with the registered manager who told us the board had been, "Like that for a while." They told us they would review how the board was used to make it meaningful for people who were able to recognise symbols.

● One person had a health action plan in their care plan that included symbols. We asked staff if the person would understand this document in this format. The staff member confirmed they would not.

● People living at The Wheelhouse had complex communication needs and the registered manager said the current health professional support for this was limited. They said however they would complete referrals for professional support.

● Care plans were detailed and person centred in areas.

● However, one section of a person living at The Wheelhouse care plan did not reflect their current need regarding their personal care. We discussed this with the registered manager and they said they would update this.

● One person was attempting to leave the building during the inspection because they were confused about the timing of a home visit with their family. There were guidelines in place to support the person at these times. However, we observed staff were not always following these.

● We saw examples of where care was personalised and responsive to meet people's needs. For example, The Wheelhouse had purchased a hot tub because it was identified that a person had really enjoyed this in their previous home. Another person was identified as benefitting from exercising each day and records demonstrated they went for a walk each day with staff.

● Staff described how they worked with people in ways to enable them to access the community and chosen activities. They gave examples of how they supported one person to attend swimming activity which they enjoyed. We saw a comment from a relative that stated, "Thank you for all the efforts you make to arrange swimming. It is [names] favourite pastime." People had access to three vehicles which had been modified to enable them to access the community.

● Staff told us how they supported people to attend a range of activities, such as a sailing club, gym,

carriage riding, holidays, going out for meals, haircuts and recycling. One person in the supported living service was attending the gym, and it was noted that this had a very positive impact on their wellbeing.
● We saw an example of where staff had supported a person in the supported living service with their continence. This had resulted in them no longer wearing continence wear, which was noted to have a very positive impact on them.

Improving care quality in response to complaints or concerns
● There was a complaints procedure displayed by the entrance of The Wheelhouse. It would be unlikely that people using the service would be able to use the procedure, but it was clear for visitors to see.
● There had been one complaint to the service which related to people using it. This had been investigated and changes put in place to prevent a repeat of the concern.
● Relatives told us they would be happy to raise a concern if needed and were confident this would be responded to. One relative said, "I've never had to but we would do. I am happy they would respond."

End of life care and support
● The service had not provided any end of life care but hoped to be able to support any person where this was needed.
● Staff had sought advice from a psychologist so they could support a person who had experienced the death of a close family member, in a kind and consistent way.

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

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

There were two registered managers in post, one at The Wheelhouse and one at the supported living service.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care

- At our last inspection in July 2016 we made a recommendation to the provider to seek guidance on ways of improving their quality monitoring systems. This was because their quality monitoring systems were not fully effective. During this inspection we found the quality monitoring systems had not improved and were still ineffective in The Wheelhouse.
- The quality assurance processes did not pick up on the issues identified during the inspection.
- Systems had not been effective in ensuring safeguarding was consistently reported to the appropriate authorities in line with safeguarding procedures. They had not identified concerns relating to non-compliance with the Mental Capacity Act 2005.
- We observed some poor cultural practices and staff interactions with people at The Wheelhouse which did not promote people's dignity and rights.
- The registered manager told us there were no systems in place to ensure accident and incidents were monitored to identify trends or patterns. This meant there was a risk people could be harmed by a similar accident.
- The leadership and culture of the service did not ensure people living at The Wheelhouse received consistent person-centred care. The provider had failed to ensure there was sufficient oversight and governance at the service.

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

- The registered manager and provider listened and acted on our feedback and they assured us they were committed to improving the service.
- The registered manager and provider demonstrated they had taken immediate action to address our concerns and informed us of the ongoing plans they had to improve the service.

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

● The registered manager was not aware of their responsibility to notify the Care Quality Commission (CQC) of significant events in line with their legal responsibility. The provider had not used the published process to notify CQC of two Deprivation of Liberty Safeguards authorisations. We therefore had no record of the authorisations.

We recommend the provider uses the published processes to notify CQC of events in line with their legal responsibility.

● The registered manager of The Wheelhouse acknowledged they would like additional support to increase their knowledge and enable them to effectively perform their role. They said, "I need more training. The last manager showed me the ropes, but I need to know more. Some things I'm not aware of." The provider confirmed they would ensure this support was given to the registered manager.
● The provider told us managers meetings were arranged which provided support for the managers. Following our inspection, they confirmed the additional support arrangements they had implemented to support the registered manager.
● Relatives told us the registered manager in The Wheelhouse was approachable and accessible. One relative told us, "They are very accessible and accept any feedback."
● Staff commented positively about both the registered manager and the support they received. Comments included, "I feel very lucky to have a manager like [name], they are very supportive and the door is always open, they are very approachable" and "[Name of registered manager] is approachable and hands on."
● Staff commented positively about working at The Wheelhouse and the supported living service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●People's feedback and views were recorded on monthly one to one meetings that were held with people and staff. We reviewed the meeting records and the questions covered areas such as activities, their room, food, about the staff, "Do you like the staff" for example and "Do you like the people that you live with." This would not be suitable for everyone living in the home due to their complex communication needs and their ability to understand this.
● Relatives told us they were kept up to date with information and felt they could voice their opinions and would be listened to.
● Staff confirmed regular staff meetings were held to discuss any concerns and relevant topics. One staff member said, "We have them once a month and yes I feel listened to."

Working in partnership with others
● The service worked in partnership with other organisations to support care provision. For example, advocates, learning disabilities team, social workers and health professionals.

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 11 HSCA RA Regulations 2014 Need for consent The correct procedures were not always followed where service users lacked the capacity to consent to aspects of their care. Regulation 11 (3)

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from potential incidents of abuse. Regulation 13 (1)

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not effective systems in place to monitor and improve the quality and safety of the service. Regulation 17 (1)

The enforcement action we took:

We imposed conditions on the providers registration.