Care Management Group Limited

Care Management Group - 4 Vallance Gardens

Inspection report

4 Vallance Gardens
Hove
East Sussex
BN3 2DD

Tel: 01273749626
Website: www.cmg.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 27 & 28 September 2016 and was unannounced.

Care Management Group - 4 Vallance Gardens provides accommodation for people who require personal care. The accommodation is a large house in central Hove providing support for up to ten people with learning and physical disabilities and complex communication needs. People were not able to communicate using speech and used body language, signs and facial expressions to let others know how they were feeling. At the time of the inspection there were eight people living at the service receiving support.

The service had a registered manager in post. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous comprehensive inspection of 9 February 2015 identified a breach of the regulations. We found the registered person had not protected people against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. We also found a number of areas of practice that needed to improve, including improvements to audits relating to cleanliness and infection control and the management of some medicines. The provider produced an action plan to tell us what they would do to meet the legal requirements.

We undertook this comprehensive inspection on 27 & 28 September 2016 and checked whether the required actions had been taken to address the breach previously identified. This report covers our findings in relation to these requirements. Improvements had been made in the areas previously identified. However, we found breaches in relation to the care of people and in the requirement for the registered person to notify us of any incident of abuse or allegation of abuse in relation to a service user.

People's respect and dignity was not always considered. They did not always receive support from staff who initiated interaction or acknowledged the person and their needs. Staff did not always take time to speak with the people who they supported. We also observed some positive interactions and it was clear people enjoyed interacting with staff. However, not all staff interacted with people in a social way or addressed people only to provide a task. A person's representative said, "I pointed out to staff a year ago that [named person's] zip was broken on his jacket. Staff helped dress him in the jacket and were going to send him out in it with the zip broken. To me it's about respect and caring what he wears."

The registered manager had not informed CQC of a safeguarding incident. This is part of the registered person's responsibilities. By not being informed of incidents, CQC are potentially unable to ensure that the appropriate actions had been taken to ensure that people were safe.

Improvements were needed to ensure that people's prescribed medicine was administered as directed to protect people from potential risks associated with medicines. A medicine recorded on the Medicine Administration Records (MARs) was not given as directed by the GP.

People's support plans were extensive but not always up to date. Not all files were updated to reflect changes or to ensure people's safety and welfare. However, those plans that were up to date were person centred and gave staff the information and guidance they required to give people the right support. People had clear support plans and guidance in place to ensure staff were able to effectively support to help meet their sometimes complex specialist support needs. We identified these as areas of practice that required improvement.

Staff had received training about protecting people from abuse, and they knew what action to take if they suspected abuse. Systems were in place to ensure people were protected from the risk of abuse. Risks to people's safety had been assessed and measures put in place to manage any hazards identified. The premises were maintained and checked to help ensure the safety of people, staff and visitors.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The manager and the management team understood their responsibilities under the Mental Capacity Act 2005. Mental capacity assessments and decisions made in people's best interest were recorded.

There were enough staff with the right skills and knowledge to meet people's needs. The relative of one person told us, "[Named relative] didn't want to go out and the staff gradually got him to take small steps each day and now he goes up to the café twice a week and he really enjoys that." Staff received the appropriate training to fulfil their role and provide appropriate support. Staff were supported and worked well as a team. They told us they were supported by the registered manager and by one another.

Recruitment practices were safe and checks were carried out to make sure staff were suitable to work with people who needed care and support.

People had access to the food that they enjoyed. People's nutrition and hydration needs had been assessed and recorded. People were encouraged and supported to be as independent as possible. People were supported to remain as healthy as possible with the support of healthcare professionals. One representative told us, "[Named person] should be having some control over his weight and he is supposed to have a healthy diet. He takes things out the fridge and now he has his own fridge for snacks. They put snacks in it like yogurt but they could put in cut up vegetables."

People participated in activities within the service and the local community. One member of staff told us, "[Person] is quite insular and it can be quite difficult to get a response from them but we have a music therapist who visits and to see them respond by dancing is wonderful." There were enough staff to support people to participate in the activities they chose.

Processes were in place to monitor and improve the quality of the service provided to people. The provider had a vision and set of values that were followed and implemented by the registered manager and staff team. The registered manager was well regarded by people's representatives and staff. One relative said, "The new manager is better. When I talk to her, she takes notes and she definitely does things. She went out of her way to get some equipment for [my relative]."

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one

breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told 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 consistently safe.

Improvements were needed to ensure that people's prescribed medicine was administered as directed.

Risks to individuals were safely managed and there were enough staff to keep people safe.

People were safeguarded from the potential risk of abuse.

There were robust recruitment procedures in place.

Is the service effective?

Good

The service was effective.

Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities. They were aware of the requirements of the Mental Capacity Act 2005 and DoLS.

People were supported to eat and drink to maintain good health.

People had access to healthcare professionals when they needed it.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People respect and dignity was not always promoted.

Staff did not always take time to speak with people and to engage positively
with them.

People were supported to maintain relationships with people that mattered to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Paperwork associated with people's care was extensive but not always up to date.

People were offered a range of activities to meet their individual needs and preferences.

People's relatives and representatives knew how to make complaints and said they would feel comfortable doing so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager had not notified CQC of an incident at the service.

The registered manager was approachable and supportive.

There were systems in place to monitor and improve the quality of the service.

Care Management Group - 4 Vallance Gardens

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 checked 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 the service on the 27 & 28 September 2016. We previously carried out a comprehensive inspection at Care Management Group - 4 Vallance Gardens on 9 February 2015. We identified areas of practice that needed improvement in relation to the cleanliness of some of areas of the service, audits relating to cleanliness and infection control and the management of some medicines. The service received an overall rating of 'requires improvement' from the comprehensive inspection on 9 February 2016.

This was an unannounced inspection. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spent time with people who lived at the service. We spent time in the lounge, kitchen and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted. People were unable to use structured language to communicate verbally with us, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with those that knew people well, we spoke with three relatives or friends of people. We gained the views of staff and spoke with the registered manager, deputy manager and three support workers.

Before our inspection, we reviewed the information we held about the service. We considered information that had been shared with us by the local authority and looked at the record of notifications. A notification is

information about important events that the provider is required to tell us about by law. A Provider Information Return (PIR) was submitted prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection, we reviewed the records of the service. These included staff training records and procedures, audits and three staff files along with information about the upkeep of the premises. We looked at two support plans and risk assessments along with other relevant documentation to support our findings.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 9 February 2015, we identified areas of practice that needed improvement. There was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because arrangements for keeping the service clean and for adequate maintenance to ensure people were protected from acquiring an infection were not in place across all areas of the service. On this occasion, we found the provider had protected people against the risks associated with inadequate maintenance and that the service was clean and hygienic to ensure people were protected from acquiring an infection.

The provider supplied CQC with an action plan that detailed how they would implement improvements to address concerns and breach identified at the previous inspection. At this inspection, we checked to see if the provider had followed their action plan. We found the following was achieved and embedded into practice; Floor surfaces in people's bedrooms were replaced where it was identified as a need. Maintenance to areas of concerns were fixed and a deep clean of the whole house was undertaken. The cleaning schedule was revised, updated and added to the daily shift planner for staff to follow. This cleaning schedule incorporated a weekly deep clean of people's rooms. Therefore, the provider had addressed this breach.

Improvements were needed to the way medicines were monitored and managed. We could not be assured that people had received their medicine as prescribed. We looked at the medicines given by staff against the instruction for their administration. A medicines recorded on the Medicine Administration Records (MARs) was not given as directed by the GP. In this case, the medicine a person was given did not match the instructions of the GP. The instruction for administration on the MAR sheet was not followed by staff and there were gaps of staff signatures to indicate that the medicine had been administered in the medicine administration records (MARs). The ambiguity of the dose given was identified following a pharmacy advice visit in September 2015 and yet the error continued. We were told by the registered manager that they had scheduled a medication review of medicines by a specialist nurse for later the same week and would address the concerns with them. We have therefore identified this as an area of practice that needs improvement.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They were able to describe the possible signs that people may display if they were unhappy. They could explain the steps they would follow if they were concerned that a person was at risk of harm. The provider had policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. One member of staff told us, "People living here are potentially very vulnerable but I have had no concerns about safeguarding since I started working here. If I had any concerns at all, or saw something I did not think was right, I would first make sure they were safe and then immediately go and report it to [the registered manger]."

Potential risks to people in their everyday lives were assessed and managed to protect them from the risk of harm. For example, one person enjoyed drinking hot beverages and had their own tea set to enable greater independence. We saw this person in the lounge enjoying their tea. Staff we spoke with were aware that this person should not be given very hot drinks and were able to explain why this person received support to make choices even though it was identified there were risks associated with the activity. For example, one person was a smoker who did not possess capacity to fully understand the risks to their health from the activity. Staff had devised a timetable, which supported the person when they request cigarettes. This was displayed for staff to follow. Staff explained it provided structure for the individual as the risk was assessed that they would continuously smoke without intervention and support.

The premises equipment was checked and maintained to help ensure the safety of people, staff and visitors. Records showed that portable electrical appliances and utilities were maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Where issues were identified, the registered manager took prompt steps to meet the identified need. For example, a weekly test identified a problem with a first floor fire alarm. The registered manager reported the issue and used an additional manually activated alarm in the location until the issue could be resolved. Individual's safety in the event of an emergency such as fire, had been carefully considered and recorded. A weekly safety check was completed which included a walk around of the building to look for and address any potential safety hazards. A system was in place to monitor and record any maintenance issues that were found within the service. These were reported quickly to either the providers own maintenance team or external contractors once they had been identified.

A record of accidents and incidents was reviewed to look for patterns that may suggest a person's support needs had changed. The system was also subject to review by the provider so that for example, they were able to check that an action plan was generated following an accident or incident.

There were sufficient staffing levels to keep people safe and support the health and welfare needs of people. We looked at staff rotas and identified that of the 16 core staff working at the service, 12 had begun working there in 2016. The registered manager acknowledged the difficulties they had faced recruiting and retaining staff as the former registered manager had left to work in another of the provider's services and taken some staff with them. Relatives and visitors comments reflected this change, one relative said, "There have been a lot of experienced staff who have left." Another said, "They were short staffed recently. Once I went in, there was no one who could get any money out of the safe." The registered manager reviewed the deployment and duties of staff to ensure the maximum support for people. They planned the rota to ensure there were enough staff to meet people's needs safely. For example, we saw that shift patterns were changed to reflect different levels of support people required in the evening. They had been amended to give staff a protected 15 minutes handover period for staff to give the next shift coming on duty. People's care and support needs were assessed and staffing level to meet those needs were determined. Staffing levels seen during the day of our inspection matched the level identified as that required to meet people's needs.

The provider had effective systems in place for the safe recruitment of staff. Records showed that recruitment checks were in place to ensure staff were suitable to work at the home. Prior to their employment starting there were security checks completed and employment history was gained. Disclosure and Barring Service (DBS) checks were carried out for all the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

Good

Is the service effective?

Our findings

Relatives, health and social care professionals thought staff were trained to meet their family member's needs. The relative of one person told us, "[Named relative] didn't want to go out and the staff gradually got him to take small steps each day and now he goes up to the café twice a week and he really enjoys that."

People were supported by people who had the necessary skills. There was a commitment to ongoing staff learning and development. New staff were supported to learn about the provider's policies and procedures as well as people's needs. Staff told us they had received induction training when they began work at the service and they had received up-to-date essential training. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. One member of staff told us, "I had a period of shadowing and days off the floor to look at files and policies in the house and peoples care plans. I appreciated the time and it helped me to learn about the people and strike up a good relationship with them from the start." Training records confirmed that staff had completed the providers own induction programme, skills for care common induction standards or care certificate. The care certificate is an identified set of standards that health and social care workers adhered to in their daily working life. It covers the learning outcomes, competences and standards of behaviour that must be expected of support workers in health and care sectors and replaces previous common induction standards. Staff received additional training that recognised the complex health care needs of the people they supported. Additional training was undertaken that reflected the needs of people and included eating and drinking for support workers and epilepsy. Some staff had obtained the National Vocational Qualifications (NVQ) or the more recent Diploma in Health and Social Care.

People were cared for by staff who had access to appropriate support and guidance within their roles. Staff told us of they were supported by the registered manager in their work. Staff had received regular individual supervisions in line with the provider's policy and included an annual appraisal. Staff supervisions records were comprehensive. The supervisor followed up on action plans from previous one to one supervisions to ensure actions were implemented. One member of staff told us, "I had my probationary meeting at six months and the next supervision is due and we need to set the date but I know that when I need to, I can talk the [the registered manager] at any time."

People received sufficient quantities of food and drink and efforts were made to provide a choice in this essential aspect of daily living. For example, one person had their own small fridge in the kitchen in which they kept their own food. We looked in the person's fridge. It contained healthier snacks and bottles of flavoured water. We asked a staff member if the person was on any special diet plan and they told us they were on a healthy diet. One representative told us, "[Named person] should be having some control over his weight and he is supposed to have a healthy diet. He takes things out the fridge and now he has his own fridge for snacks. They put snacks in it like yogurt but they could put in cut up vegetables." The weekly menu planner in the kitchen showed that healthy, freshly prepared food was available to people. On the days we were present we saw that dishes were prepared using fresh ingredients. We also saw that staff knew people's preferences. For example, they told us one person did not like the homemade soup being prepared and arranged for an alternative to their liking to be made available. People's weight and nutritional intake were

regularly monitored and referrals were made to Speech and Language Therapists (SALT) or dietician if people's nutritional intake reduced or staff had any concerns around people's nutrition and hydration.

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, learning disability nurses, speech and language therapists (SALT) and physiotherapists. Staff knew people well, were able to recognise any changes in their behaviour or demeanour and ensured they received appropriate support in response to noted changes. For example, in response to changes in the health of a person, a physiotherapist assessed them. There followed a referral to the occupational therapist for additional advice and the providers own moving and handling trainers put measures in place to reduce the risk. Relatives told us staff ensured that people had access to medicines and healthcare professionals when they were not well. A professional with knowledge of the service said, "Staff are knowledgeable and helpful about [named person]. They are proactive. They want to know if there's any more they can being doing to meet their healthcare needs. I couldn't do my job without the team here."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was working within the principles of the MCA. They understood the requirements of this legislation and had acted in accordance with it and therefore ensured that people were not deprived of their liberty unlawfully. For example, some people may have had bed rails in place but lacked capacity to consent to their use. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety, but do restrict movement. The registered manager had ensured that less restrictive options were considered, such as the use of low profile beds. Mental capacity assessments were decision specific and assessed the person's ability to understand the information related to the decision being made. Records showed how the decision of capacity was reached.

Requires Improvement

Is the service caring?

Our findings

We observed staff engaged in positive caring relationships with people and saw examples of genuine warmth between people and staff. Two representatives we spoke with both singled out the same member of staff for special mention, one told us, "[Named staff member] is so good with [my relative]. They speak to him so well." Another relative said "There is a guy called [named member of staff] who has really bonded with [person] and always takes him out." However, we observed that not all staff displayed such a caring approach.

We used observation to look at care and support. We observed several examples when staff ignored people when they entered a room. Some staff appeared to be task orientated and not open to engagement with people. For example, two members of staff were seen folding items in the lounge over several minutes and did not acknowledge the presence of the people around them. At other times, we observed occasions when staff did not respond to the needs of people appropriately. A member of staff was observed to stand impassively, often with their arms crossed, and not engaged with people. The staff member did not show any emotional support to people. On one occasion, we heard a commotion coming from the lounge while we sat talking with the registered manager in the closed office. We emerged with the registered manager to find a person had fallen. The same member of staff was exercised by the fall but their focus appeared to be a broken chair and not the welfare of the person. They were shouting and argumentative with colleagues and swore at one point. They were successfully deployed elsewhere in the service to support others while other staff made the person comfortable and safe but the examples noted did not communicate caring values.

We found that people's respect and dignity was not always considered. For example, we saw a person transferred from a chair to a wheelchair by the use of a hoist. This person's individuality was not considered during the transfer, as there was no interaction with them by voice, touch or use or other non-verbal communication methods. Another person stood just inches from where the person was transferred and there was also no communication from staff as they were steered out of the way of the hoist. We asked relatives and representatives how people's dignity was maintained. One relative said, "I feel [my relatives] personal hygiene is not always sufficient. They are doubly incontinent and not always clean when they come to me. Also, when they came to me after I had been away, I had to really scrub their nails as they were black and really filthy." Another person said, "I pointed out to staff a year ago that [named person's] zip was broken on his jacket. Staff helped dress him in the jacket and were going to send him out in it with the zip broken. To me it's about respect and caring what he wears."

The above evidence demonstrates that people were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At other times staff interacted with people in a caring and compassionate way. Staff gave people time and spoke with them face to face to facilitate effective communication. They knelt down when they talked with people so that they were at the same eye level. They used touch to communicate genuine affection, concern and care for the individual. Some staff showed that they knew people well and demonstrated compassion and respect in terms of understanding what was important for an individual in delivering person centred

support and care. They understood the needs of people and we were able to confirm this through discussions with people's representatives.

We observed staff maintained people's privacy. We saw and heard staff knocked before entering people's bedrooms. Staff told us that they maintained people's dignity by, "Knocking on people's doors before going into a bedroom when the door is closed, speak with people and explaining what you're going to do. Also making sure the curtains are closed." Another member of staff told us about their approach if people showed signs that they were anxious or upset. They said, "You try to encourage them to show you what's wrong or what they want and what you can do to make them more comfortable." Staff understood the needs of people and we were able to confirm this through discussions with them. Staff answered our questions in detail. For example, one staff member described the support they provided to someone who was receiving care in bed because of an illness. This showed us that staff were aware of the up to date needs of people.

It was recognised that people needed additional support to have a say in their support and the registered manager had sought to involve people's relatives when it was appropriate. People were able to access an advocacy service. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options, defend and promote their rights. A range of relatives, friends and professionals contributed to people's support plans. We asked family members and friends if they had been involved in their care planning. They felt that they were included and kept up to date. One person said "I know there is a care plan and they do talk to me about things in it." Another person said, "The last social services review was in 2015 and there has been a six month review since then. I am normally invited. But I get to talk to [the registered manager about [my relative] at other times." Friends and family were able to visit. A relative said, "As for visitors, they always ask if we want a drink. They are very polite."

Requires Improvement

Is the service responsive?

Our findings

Each person living at the service had a plan of their support, based on an assessment of their needs. However, not all information in the plans were up to date or consistently completed. A relative we spoke with told us they were involved in reviews for their family member. They told us, "I'm given a copy of the review." People's bedrooms and communal areas were designed to be stimulating for people.

Each person had a support file, they contained personal information, which recorded details about people and their lives. They included assessments that covered personal care, nutrition, mobility and individual communication methods including gestures, signs and body language. A relative described how staff were able to communicate effectively with their family member and how this had improved their quality of life because being understood reduced their frustration. Information was also held in people's separate health file and contained the support required to meet peoples sometimes complex health needs. However, we found inconsistencies between individual files that we viewed. While files were person centred, some did not contain up to date important information about the person or had not been completed in full. From the information that was made available to us, we could not be assured people were receiving the support they required, as their files were not updated to reflect changes to support.

In one person's support files, there were details about their care and support needs and how they liked to be supported. This included their preferences for how they liked their personal care to be carried out. It included details around continence care, guidance with transfers and types of food and drink that they liked at certain times of day. However, this level of up to date detail was not reflected in all the plans for people. For example, one person's individual risk management plan dated from October 2015 and in response to changing needs was due to have been reviewed in April 2016 but there was no evidence this had been accomplished. Another person's support and care needs were developing in response to changing health needs. We saw that reviews had been carried out with health professionals that meant there were changes to care. For example, one person had begun to use a repose boot to help reduce the danger of developing pressure sores but not all parts of the support plan had been updated to highlight this change in care. We spoke to the registered manager about this and they told us that reviews were being carried out and that there were changes in the people's needs that were not reflected in their support files. We were encouraged by the positive steps the registered manager, deputy manager and key support workers had taken to achieve the goal of having up to date plans and saw that 6 out of 8 people's files were up to date. However, two plans were out of date as judged against the provider's policy of regular review to reflect peoples changing needs, one by nearly twelve months. We have identified this as an area of practice that needs improvement.

People were provided with meaningful interaction and stimulating activities at home or out in the community. People's bedrooms were personalised and adapted with their own belongings such as cuddly toys, religious artefacts and music memorabilia. People and their families were supported to individualise their rooms with items that were meaningful to them. Access to the community was planned for individuals at different times, which also enabled other people to enjoy individual personal time and space in the communal areas and in their bedrooms. Support was provided that enabled people to take part in social

activities. This included regular access to the local community. We saw people going about their daily lives popping out to their favourite coffee shops, going out for a walk or visiting the nearby community based development centre. There was meaningful interaction with people to promote stimulation and engagement. The registered manager told us that staff were encouraged to work in a creative way to enhance the lives of those they supported. One member of staff told us, "[Person] is quite insular and it can be quite difficult to get a response from them but we have a music therapist who visits and to see them respond by dancing is wonderful." We saw this reflected in an arts and crafts session in which people were encouraged to observe and participate as much as they wanted to. A health care professional told us, "I have seen lots of nice interaction between carers and residents there is a nice atmosphere." One relative told us, "There is a guy called [named member of staff who has really bonded with [person] and always takes him out." But another representative voiced a concern when they said, "They took the van away as there was no driver." We discussed this with the registered manager who acknowledged the concern had been raised with them but pointed out that they used transport available at the providers other locations nearby and used taxi's and other means of public transport when it was appropriate. They also pointed out that the service was close to the centre of Hove and only metres from the seafront, with the facilities that offered. Records of activities undertaken by people showed that their abilities, level of engagement and enjoyment were monitored to ensure that the activities were suited to their needs, preference and choice.

The provider's complaints policy and procedure was made freely available in the service and contained details of relevant external agencies and the contact for details for advocacy services to support people if required. Staff were able to explain the importance of listening to, or recognising, when people were concerned or upset and described how they would support people in these instances. For example, one member of staff said, "I can tell if [person] is happy, it can be seen in their face. Equally if they are bored or upset about anything you will get no reaction to a prompt." We received positive comments from one person's relative about how the new registered manager was able to deal with any concerns in a helpful and friendly way. We asked about how the service listens and responds to complaints and concerns. One relative told us "There has been an improvement with the new manager but the TV broke down and it took 2-3 weeks for them to put a replacement in." We asked the manager about this and were told, "Yes, the TV was without a picture for 2 weeks. I took it upon myself to get a replacement as quickly as possible as people enjoy it."

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not informed CQC of a safeguarding incident. This is part of the registered person's responsibilities. By not being informed of this incident, CQC were potentially unable to ensure that the appropriate actions had been taken to ensure that people were safe.

Part of registered person's responsibilities under their registration with the Care Quality Commission is to consider guidance that is provided in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered manager's responsibility to notify us of certain events or information. The registered manager had not notified us of a safeguarding incident. Registered managers are required to inform CQC of these incidents to enable us to have oversight to help ensure that appropriate actions are being taken and to ensure people's safety. The registered manager explained that they had reported it to the local authority and their line manager. It was evident that the registered manager had been transparent and open with other events that had occurred within the home. While it is recognised that on this occasion there was a genuine misunderstanding that had led to the lack of notification in relation to the incident, it remains the responsibility of the registered person to ensure that they are aware of notifiable incidents.

The above is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

The registered manager was appointed in January 2016. We asked people's relatives and representatives if they thought the home was well led One relative said, "The new manager is better. When I talk to her, she takes notes and she definitely does things. She went out of her way to get some equipment for [my relative]." Another relative expressed some frustration historically and said they had been made to, "Feel like I am talking to the wall." However, they also acknowledged that "The new registered manager is working hard to make a lot of changes"

Staff confirmed that they felt the manager was approachable and that they could speak with her when they had a question or concern. One member of staff gave an example of an improvement to the delivery of support to people that they suggested which the manager accepted and actioned. The registered manager took an active role within the running of the service and had good knowledge of people and staff. We observed throughout the inspection the registered manager spent time with people and talked and interacted with them and their visitors. Both the registered manager and their deputy worked on shift with people, yet there were clear lines of responsibility and accountability within the management structure. A member of staff told us, "[The registered manager] is a good role model. They have a lot of experience in care. They worked in the service before becoming the manager so really know the people. I've learned a lot from the manager, occasionally allowing me to make mistakes and learn from them. They are always available to ask them a question."

The visions and values of the provider promoted a personalised, safe and stimulating environment where people were able to develop their social, communication and life skills with a view to gaining greater levels of independence. The registered manager described their philosophy of support that reflected these values.

They and their deputy took seriously their sense of responsibility to ensure that people were happy and listened to and that they were supported to exercise choice as much as possible. The registered manager had been in post for 9 months, their deputy was appointed in June, and both told us they were supported by the provider to work to further embed a positive culture in the service and in the practice of staff. They told us, "The regional director is always available."

A range of quality assurance audits were completed by the registered manager and regional director to help ensure quality standards were maintained and legislation complied with. These included audits of medicines, support records and health and safety. They identified trends, concerns and helped identify necessary improvements to the service. For example, in the section on 'Keyworker and Service User Meetings,' It was noted that, 'There is evidence of discussion in some key worker reports that feedback is sought. There is room for improvement in this area', and we confirmed with staff that opportunities to spend time on this important area had been given.

There were links within the organisation to ensure the most effective and appropriate support was provided for people. The registered manager kept up to date with new practice ideas, as demonstrated by their attendance and contribution to the Care Management Group manager's meetings, the epilepsy specialist interest group and profound and multiple learning disabilities (PMLD) forum. The registered manager worked in close partnership with organisations and healthcare professionals to support people's care provision and service development. The provider had accreditation to recognised schemes such as Skills for Care, The National Skills Academy and The British Institute of Learning Disabilities. We noted the following feedback from a health care professional, "[There is] hard work, dedication and commitment in continually striving to achieve high quality, person centred care."

Staff understood the management structure of the service, who they were accountable to and their role and responsibility in providing support for people. The registered manager made sure that staff were kept updated regarding people's care and support needs and about any other issues regarding the service. Regular team meetings were held in which staff could discuss practice, give their views about the service and suggest any improvements. A communication book was used to highlight any changes in people's care and support needs, this ensured staff were aware of any changes in people's needs and had up to date information to support people. The provider required that this was read at the start of each shift. For example, we noted the following messages left '[Named person's] wheelchair has buckled, do not use it until it is fixed' and 'Pictures have been taken of activities with [person]. Need to make a board to display these.'

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18: Notification of other incidents Care Quality Commission (Registration) Regulations 2009 The registered person must notify the Commission without delay of any incident of any abuse or allegation of abuse in relation to a service user which occur whilst services are being provided in the carrying on of a regulated activity. Registration Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and Respect Service users must be treated with dignity and respect. Not all communication with people using services was respectful. This includes using or facilitating the most suitable means of communication. Regulation 10 (1).