Optalis Limited

16 Homeside Close

Inspection report

16 Homeside Close
Maidenhead
Berkshire
SL6 7RB

Tel: 01628630710
Website: www.optalis.org

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection took place on 16 October 2018 and was announced.

16 Homeside Close is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides accommodation and personal care to adults with learning disabilities or autism spectrum disorder. The care home accommodates eight people in one adapted building.

The care service had been developed and designed in line with the values that underpin the "Registering the Right Support" and other best practice guidance. These values 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.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, responsive and well-led to at least "good". The service has made improvements, which included compliance with a previous breach related to good governance. The ratings for key questions responsive and well-led have therefore improved to "good". Further improvement is required for key questions safe and effective.

The provider is required to have a registered manager as part of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was a manager registered with us.

Staff reported accidents and incidents. However, documentation of actions to check people were safe and to prevent recurrence of injuries were not always recorded. The house was generally clean and tidy but improvements were required to mitigate the risks from infections. New care risk assessments were in place and more were to be implemented to cover other areas of care, such as people's moving and handling.

The service did not ensure they followed the requirements set out in the Mental Capacity Act 2005 on every occasion. We made a recommendation about this. People's health and social care appointments were not always followed-up in line with requirements from their own health action plans. More staff supervision and training had occurred, to ensure people were supported by care workers with appropriate knowledge and skills. We made a recommendation about recording staff performance appraisals. Changes made to the premises ensured a better environment for people who used the service.

People received kind, compassionate care from dedicated staff who knew them well. People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way

possible. The policies and systems at the service supported this practice. People had an active say in how the service was operated and managed.

The introduction of new care plans had increased the service's focus on person-centred care planning and delivery. More information was provided and available to people in a way they could understand it, including photos, pictures and symbols. This could be further improved. End of life care planning was evident for only some people; more documentation about people's preferences for a peaceful, dignified death is required.

The governance of the service had improved. A better-quality assurance programme was in place to check, measure, log and act on areas for improvement. There was more oversight from the provider, and increased support to the registered manager. Staff continued to support people in a positive workplace culture. Staff were encouraged to be more included in the operation of the service. People were protected from abuse, neglect and discrimination. The values of equality and diversity were respected and observed by the staff, registered manager and provider.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's incidents and accidents were reported. Actions were not always taken to prevent recurrence of potential and actual harm

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People were not always protected from the risks of infections. Further action was required to minimise the potential for infections.

New care risk assessments were implemented. Further risk assessments are required to assess and mitigate all relevant care risks.

There were sufficient staff deployed to meet people's needs. Recruitment processes ensured fit and proper persons were employed.

Staff protected people from discrimination, abuse and neglect.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not ensure they followed the requirements set out in the MCA and DoLS on every occasion.

People's health and social care appointments were not always followed-up, which compromised their right to a healthy lifestyle.

People were supported by staff who received required training and supervision sessions.

The premises were adapted and modified to ensure a better environment for people who used the service.

People were protected from the risks of dehydration and malnutrition.

Is the service caring?

Good

The service was caring.

People said, and we observed, good interactions with staff.

People had developed trusting relationships with staff.

People were involved in care decisions and were asked how support should be provided.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Improvements were made to promote person-centre care. Further care plans were necessary to cover all care and support provided to people.

People's communication needs were assessed in line with the Accessible Information Standard.

People and others had appropriate information available to them if they wanted to raise concerns or complaints.

End of life care preferences were in place, but not for all people who used the service.

Is the service well-led?

Good

The service was well-led.

Improved governance systems were in place to gauge the safety and quality of people's care.

Actions were created, and most were acted on, to manage areas for improvement at the service.

There was a clear strategy for continuous improvement. This included the development of the "customer" [people's] experience.

There remained a positive workplace culture for staff. More training and staff discussions occurred, to promote inclusivity of staff in the service's development.

16 Homeside Close

Detailed findings

Background to this inspection

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

Our inspection site visit took place on 16 October 2018 and was unannounced.

Our inspection was completed by an adult social care inspector and assistant inspector.

Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House, the Food Standards Agency and the Information Commissioner's Office (ICO).

We asked the service to complete a Provider Information Return. This is 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 did ask the service for a list of health and social care contacts prior to our inspection, and this was returned by the due date.

People who used the service were able to provide limited information to us, however we spoke with them as part of our inspection. We also spoke with the provider's head of regulated services, the registered manager, and three care workers. We reviewed four people's care records, one personnel file, medicines administration records and other records about the management of the service.

After our inspection, the registered manager sent us further information. This evidence was included as part of our inspection. We also wrote to the provider after our inspection to seek further information and evidence, which we used to inform our judgements.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 21 September 2017, this key question was rated "requires improvement". This was because we found evidence that medicines were not always managed correctly, a system to determine staffing deployment was not in place and risks from the building and premises were not always acted on. Whilst there have been improvements in these areas, we found other evidence which demonstrates the service still requires improvement in this key question. The service must continue to make improvements to increase the rating to at least "good".

Medicines were correctly ordered, stored, administered, recorded and disposed of. We checked people's medicines administration records (MARs) and found medicines were given and there were no missing signatures. Two care workers administered medicines together to ensure that people safely received what was prescribed. MAR charts did not indicate remaining quantities of medicines at the end of monthly cycles. We informed the registered manager of this so they could take action. We checked the containers which creams and lotions were stored in and these were correctly dated and discarded, in line with best practise. People had protocols in place for 'as required' medicines which clearly stated the dosage, indication and how frequently the drug could be provided. There were 'homely remedies' such as over-the-counter paracetamol. These were satisfactorily managed and the running balance of stock was recorded. A pharmacist audited the medicines annually and provided recommendations. These were actioned and signed off when complete. Staff were required to complete annual medicines administration competencies.

The management of risks from the building and premises had improved. The service had followed the recommendation from our previous inspection regarding record keeping. Although staff always reported issues, they did not always ensure that required repairs were completed. Copies of risk assessments and records of actions taken were available on site, and there was consistency of the record-keeping for this. We saw records of checks such as fire safety, window restrictors and water safety. However, when staff completed checks, they often repeated the information from the prior check and failed to notice an action remain unresolved. An example was an emergency light that was not repaired for three consecutive months. We also noted a fire door in the dining room was not kept open correctly. A pull cord for the staff call was broken and not repaired. We alerted the registered manager to this who organised for these issues to be attended to during our inspection.

People's risk assessments for care and support were completely replaced following our previous inspection. The provider had designed new templates and these were implemented by the service's staff. They contained sufficient detail for each person and provided the initial risk rating for activities of daily living as well as strategies for mitigating risks. However, there were support areas which lacked any risk assessments. Examples included moving and handling and skin integrity. We pointed this out to the registered manager for consideration. In addition, some risk assessments did not provide clarity for staff. The provider's representative acknowledged that documentation was a "work in progress". For example, people's emergency evacuation protocols (PEEPs) used crosses to answer yes/no questions and ticks were used in the medication risk assessments. This could lead to confusion with staff being unsure as to how to support the person. One PEEP identified that the person required "prompts and encouragement to manoeuvre" to

evacuate the building. The plan did not identify what these prompts were.

People's accidents and incidents were reported by staff. We examined the content of two incident reports. We noted that there were missed opportunities for mitigation of the risks which were reported. This included one person who had a choking episode (without serious injury). The incident report did not have a recorded written review by a senior management team member, and referral to an appropriate health and social care professional was not made. There was no information about how the person's food, drinks, eating, chewing and swallowing were managed. The second incident involved the same person who tripped on uneven paving at the rear of the building. There was evidence that the registered manager and provider had attempted to have the paving repaired by the landlord. However, the paving risk remained unmitigated. At the time of our inspection, there was unrestricted access to the uneven surface. This placed not only people, but staff and visitors at risk of trips and falls. We wrote to the provider after our inspection to ask them to provide evidence the risk was properly mitigated. After our inspection site visit, the provider contacted the landlord. The affected area was cordoned off. Corrective works were completed to mitigate the risk of trips and falls from the uneven surface. Documentary and photographic evidence was provided to us which demonstrated this. We were satisfied this risk to people and others was mitigated.

People were not always protected from the risks of infection. Staff received regular training in infection prevention and control, and the registered manager told us that a staff member was nominated as a 'champion'. However, the staff member had received no specific training, and did not contribute to processes such as sharing knowledge and best practise, completing risk assessments and taking actions where improvements were required. People's bedrooms and communal spaces were generally clean and tidy. In bathrooms and toilets, we noted personal protective equipment (gloves and aprons) were placed near the floor. We also observed that clinical and general waste bins were not pedal-operated. This increased the risk of cross contamination when staff had contact with the top of the bins. There were areas where dust had accumulated without being cleaned adequately. The registered manager showed us a list used by night staff for recording cleaning. The list was not specific enough and did not set out the frequency for cleaning particular areas. Infection control audits were completed by the provider and actions were placed into the service's improvement plan.

The service's night care records did not individualise checks to each person. Staff indicated the checks were undertaken by putting a tick next to a time on the forms, however these do not identify who was checked and what occurred during the check. The registered manager described these as a 'walk around'. Checks were often recorded as being undertaken at two, two and a half or three hourly intervals; these varied on different days and by different staff. This indicated an inconsistent approach to care by staff and that they were potentially putting people at risk by not checking on them at the expected intervals.

People remained protected against the risk of abuse. Staff ensured people were not discriminated against, and recognised their unique characteristics when they provided support.

The provider had acted on the recommendation about staffing from our prior inspection. Sufficient staff were deployed to meet people's needs. The staffing levels had not changed since our last inspection. However, the service had implemented a system for measuring the number of care hours each person required per day and week. This data then informed the provider how many staff to roster on each shift. Staff were not rushed and people received their care in a timely way. There remained vacancies for care workers and there was also a lack of bank workers. This meant agency staff continued to be deployed for a few shifts each week. The agency workers were regular and this contributed to the consistency of staffing people were supported by. The provider's representative explained recruitment methods that were used, although agreed that filling the vacant roles was difficult. The personnel file we checked contained all the

necessary documentation prior to a new staff member commenced. This ensured that only fit and proper persons were employed to care for people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 21 September 2017, this key question was rated "requires improvement". This was because we found evidence that staff training, supervision and performance appraisals were overdue and that the service required further decoration to provide an effective environment for people with learning disabilities. At this inspection, we found evidence that the service had taken steps to act on the issues outlined in our previous report. However, there remains care issues that require further improvement. Therefore, the rating for this key question remains at "requires improvement".

People were supported by staff who had appropriate knowledge and training. We saw that the amount of staff who had completed their mandatory training subjects had improved. Staff had completed training in topics such as fire safety, basic life support, safeguarding and moving and handling people. The registered manager provided evidence that staff were offered and participated in more regular supervision sessions with their line manager or buddy. The registered manager told us that eight staff had completed performance appraisals since our last inspection, but these were not written down.

We recommend that the service ensures appropriate records of all staff support are maintained.

Environmental changes had occurred to improve the internal decoration for people who used 16 Homeside Close. This included new flooring throughout multiple areas of the building. In line with our guidance for learning disability services, more diagrams, symbols and pictures were used throughout the premises. There were some pictures of items in some helpful places which aided people to locate items. For example, kitchen cupboards were labelled with pictures to show where items were kept, for example where foods and drinks were stored. This helped people develop their independence skills. The provider had not acted on the recommendation from our prior inspection about redecoration of the kitchen. We pointed this out to the registered manager the inspection so they could provide feedback to the provider about this. Fire evacuation instruction signage around the service was available in pictorial and easy-read versions. This helped to ensure that people knew what to do in case of an emergency. Each week the house meetings were attended by people who used the service and the evacuation actions were discussed. This provided a simple reminder for people about actions to take.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff requested verbal consent from people before supporting them or providing personal care. People's implied consent indicated staff could proceed with the provision of care. Some people could consent to

basic choices, whilst in other situations staff made the best-informed choice for the person. We did raise concerns with the registered manager and the provider's representative about a decision made for a person's medical procedure. Best-interest decision making was not completed or recorded. We asked the management team to contact the local authority for further advice and support, to ensure this did not recur.

The registered manager ensured that DoLS applications and re-applications were made when people's liberty was restricted. Copies of the required documentation were all on file and readily accessible for staff. One person's DoLS documentation, stated that the person "Requires hourly checks in order to maintain his health, safety and welfare" at night. The registered manager was unsure as to why these checks were in place and how they were to be undertaken. Contact sheets did not reflect hourly checks. For example, an entry recorded, "[The person] is alright, support him with shower and hair wash and support him to bed. No concern."

We recommend that the service reviews the requirements of the MCA and DoLS and associated codes of practice.

There was mixed evidence about the effectiveness of working with community health and social care professionals. In one person's file there was a report from the learning disability health team which identified a decline in mobility and recommended use of a wheelchair for accessing the home's vehicle. The report stated, "He has also refused to get into a taxi whilst out in the community…will always need to use the home vehicle." The person had a wheelchair in place. There was no vehicle for the service at the time of our inspection, as it was being replaced. Other information showed the service had acted on recommendations from health professionals. For example, the person was recommended to have a new bed and a new chair by an occupational therapist, and the these were in place.

The person's records showed that the staff did not always ensure the person's effective care. The "personal health plan" stated, "Me and my circle of support (carers) will look out for the following signs: feeling tired (fatigued), gaining weight, being constipated, losing my hair." There was one record of tracking weight, which was last completed in February 2018, however there were no records of the other factors having been recorded or tracked. This could lead to the person's health being put at risk. The plan also recommended that the person had a hearing test, which was not completed and there was no appointment planned. The file indicated that the person was seen by their GP when necessary, following staff concerns about the person's health. However, some routine appointments had not been recorded as having taken place in line with the recommended frequency. These included, podiatry, an ear nose and throat nurse, a dementia reassessment and accessing a dentist. This indicated that the person's health was not always being assessed appropriately which placed their health and wellbeing at risk.

People's choices about care were assessed and recorded. In a person's file there was a "hospital information form." This was an important document that was pre-populated with key information that hospital staff would need to know about the person. The form was produced recently and organised information into three categories: red - things that you 'must know about me', amber - things that are 'important to me' and green – 'things I'd like to happen'. It was clear to read and easy to follow. This was an example of good planning for sharing information which would benefit the person's care away from the service.

People had access to sufficient food and drinks. People told us about their favourite foods and drinks, and liked to have snacks and occasional takeaway meals. We observed people enjoyed their breakfast and lunch. Each person had selected their own meal and drink on both occasions. There was a board on the wall in the dining room that identified what was on the menu for that day. It had been completed for that day. It contained words and some pictures of the food, but not all the food. For example, there was a picture of

cereal for breakfast, written 'sandwiches' for lunch (no picture) and the sandwiches did not list any flavours or choices. Dinner was written but was not accompanied by a visual picture to support 'toad in the hole'. However, two people had told us that they were having 'sausages' for dinner. There was only one choice of meal on the menu board. Staff told us that people met on a Sunday evening to plan the meals for the coming week and that this is a meeting that they look forward to and participate in. This showed that people were involved in the planning of their meals and had input into the service. One person had a preferred diet and so their menu was specific to their needs. Staff said that they did the cooking and that the people who live there did not help with the cooking.

Good

Is the service caring?

Our findings

The service remained caring. There was a jovial and calm atmosphere at the service during our inspection. We observed kindness and a friendly demeanour between staff and people who used the service. People told us they liked staff and enjoyed living at 16 Homeside Close. When we asked one person about the care workers and service they gave us a 'thumbs up' and said "good." This indicated they were satisfied with the support from staff and the service. Some people liked personal touch, especially hugs, and we observed sensitive interactions with the care workers. People were happy to see the inspectors again, and some gave us a hug and told us what activities they had planned for the day.

The bedrooms were individually personalised by each person who had chosen the colour scheme and had personal items on the walls and individual furniture. Each person had chosen an image to go on their bedroom doors to identify it was theirs. We asked the registered manager about this who told us this idea was implemented following our last inspection. For example, we noted one person had a poster of a musical on their door. The registered manager said the person liked musical theatre, and therefore the bedroom door reflected their interest about this. This was a good example of people being involved in the decisions about their environment.

As part of our inspections, we check whether people's independence is maintained and promoted, and their level of involvement in decision-making. Some people's decision-making was limited. Others could communicate more decisions with staff. We observed that staff did ask people to make decisions. People were asked what they wanted to eat and drink, what activities they wanted to do, and what they wanted to wear. When a person was hesitant, staff used their knowledge of the person as a prompt. For example, a staff member suggested a meal to a person by stating, "I know you like [this type of food]…would you like to have that?" Most people were ambulant and could move about the service and into the community without assistance, but with simple supervision. People actively engaged in the local community and attended a nearby day centre as well as shops and cafes. One person continued to use their bedroom floor to complete activities, and staff observed the person periodically to check their welfare.

People's opinions of the service were measured, as far as possible. They were asked to complete surveys and the surveys were presented with pictures and in an easy-read format. Staff assisted people to answer the questions. Where people could not provide a response, staff wrote this on the survey form to indicate the person had an opportunity to take part. The provider had an engagement lead who oversaw the 'customer' experience. There was an analysis of the findings of people's feedback, and this was used to formulate ideas for changes. In addition, the weekly 'house' meeting was held to talk about outings, appointments, meals and staff. The meeting minutes showed that people had a say in how the service supported them.

People's privacy and dignity continued to be respected. People were called by their preferred names. People were neatly groomed and dressed. People's choices were respected by staff, even when they refused something. People's bedroom doors were open or closed according to their choice, and bathroom and toilet doors were closed during personal care.

Confidential information about people who used the service, staff and others was protected. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO), as required. The General Data Protection Regulation requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislative requirements for record-keeping. Records were secured when not in use. People's, relatives' and staff's confidential information was protected.

Good

Is the service responsive?

Our findings

At our last inspection on 21 September 2017, this key question was rated "requires improvement". This was because we found evidence care plans sometimes contained conflicting content, and the complaints system needed improvement. At this inspection, we found evidence that the service had taken steps to act on the issues outlined in our previous report. Further work was underway by staff, the registered manager and the provider regarding care plans. Therefore, the rating for this key question has increased to "good".

People's care and support plans were completely replaced following our previous inspection. The provider had created new proformas and these were implemented by the service's staff. They contained satisfactory detail for each person and provided staff with person-centred information. However, there were support areas which lacked any care plans. For example, this included moving and handling and skin integrity. The registered manager and provider's representative were already aware of this finding as it directly related to the part of our inspection where we examined people's risk assessments. We were told that plans were already in place to ensure people had further relevant care plans. The registered manager was working with the provider's representative and quality lead to ensure better care plans were in place.

All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. Staff had not received training in the AIS principles at the time of our inspection, however there was evidence that people's information needs were identified. There was an assessment for people's communication needs, which included whether the person had sight or hearing impairments, whether they could hold meaningful verbal conversations, and aids or devices a person may need to assist communication. The care documentation recorded medical conditions which impacted on people's ability to effectively communicate.

At the time of our inspection, no one who used the service received end of life care. The service had considered some, but not all, people's end of life choices and preferences, and where relevant had recorded them. One person's end of life plan stated that the person wanted to stay at the service for "…as long as possible" and directed staff to contact their relative regarding funeral plans. The plan did not specify what actions to take in the event of death, for example, who to contact and what to say. It also did not address the person's individual preferences for funeral plans. The plan did not identify any cultural or religious considerations or preferences of the person. We provided feedback to the registered manager about end of life care planning for people and how this could be managed.

There was a satisfactory complaints system in place at the service. After our previous inspection, further easy-read posters and information were placed throughout the building which made the complaints process clearer for people. No complaints were received since our last inspection. The registered manager knew how to deal with concerning information from people, staff, visitors and health and social care professionals. The provider had an appropriate policy in place and complaints were logged and managed by the registered manager and the provider.

Good

Is the service well-led?

Our findings

At our last inspection on 21 September 2017, there was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014. This was because we found evidence that there was not a good governance system in place. The key question was therefore rated "requires improvement". After our inspection, we requested and received an action plan from setting out what steps would be taken to achieve a rating of at least "good". At this inspection, we found the service had taken steps to improve, measure, assess and record the standard of care and take actions. Therefore, the rating for this key question has increased to "good". Further work was underway by staff, the registered manager and the provider to ensure full implementation of suitable mechanisms to measure people's safety and the quality of the care.

The registered manager was responsible for two locations, and spent time at each service. A deputy manager was employed at 16 Homeside Close, but at the time of our inspection they had commenced long term leave. This meant the post was not filled in the absence of the permanent staff member. The service had sufficient notice of the deputy manager's absence, but had not adequately planned to backfill the position. We were told an internal advertisement was to be published to all the provider's staff to attract a candidate who could act in the position. At the time of our inspection, support from another senior staff member and the provider's representative was increased to ensure adequate oversight of the service.

The service and provider had implemented some improved quality assurance processes since our last inspection. The action plan we received set out a variety of systems and checks the provider proposed to put in place to ensure good governance. We spoke with the provider's representative who advised which strategies were in place or were still underway. They told us that not all of the systems which were in the original plan were implemented. The provider determined that some systems would not be as effective as they had originally planned. The provider's representative provided an up-to-date list of the quality processes already in place at the time or our inspection, and those which were underway or planned for implementation.

The provider had deployed a quality assurance lead and head of governance and quality assurance, who had oversight and responsibility for safety of care at all the provider's registered locations. An electronic auditing system, "iAuditor" was introduced to log quality visits, required improvements, log actions arising and to track progress. The quality lead conducted a service audit on 2 May 2018. This was a comprehensive, impartial check of all care, support and quality matters. The report was detailed and set out 22 actions for improvement. An appropriate action plan was developed which detailed the determined risk levels, timeframes for achieving compliance, demonstrated who was responsible and what steps were required. We viewed the audit report at our inspection and asked the quality lead to send us an update of actions open or complete after our site visit. Examples of actions included development of PEEPs, improvements to the recording of food temperatures, staff meetings to be held more regularly, and archiving of redundant paperwork. We saw these actions were marked as "done" on the action plan. Some actions were however marked as "done" when they were not complete. For example, the information related to the PEEPs and the paving risk at the rear of the building were not completely finished. We provided feedback to the management team about this.

A further governance visit of the service was completed by the quality lead in September 2018. This showed that actions set in the prior audit were followed up by the provider. Examples of actions completed included the introduction and refinement of a "continuous improvement plan", a business continuity plan developed by the registered manager, better records related to staff training and development. Actions that were not complete were clearly set out with required time frames. For example, the service was requested to capture more evidence to demonstrate caring and effective support (linked to our key questions). The further checking of the prior audit provided assurance that identified areas for improvement were not overlooked and that risks to people were being mitigated.

The provider had introduced a clear and credible strategy for the service. The framework was rolled out in 2018 via a series of quality workshops. The provider stated, "Key front-line colleagues, managers and the senior management team attended the workshops with the purpose of improving the effectiveness of the Optalis quality assurance framework to ensure it aligns with our 2020 strategic objectives of quality, growth and value, customers and staff." A copy of the objectives was displayed in the service, along with easy-read versions for people. The service had commenced implementation of the new ways of working, although these were not fully completed. For example, there were standardised requirements for keeping health and safety and premises documentation, set frequencies for staff training and development, new forms for documenting people's care and more emphasis on gaining information about "customer experience" (people's opinions).

Other audits and check of the service were completed by staff. These included health and safety, medicines and cleaning. A new, more robust audit for infection control was ready for implementation; we received a copy of the tool from the quality lead. Use of the audit tool would help formally identify actions required for improvement. Most actions from the audits were completed, although some were incomplete or went unnoticed. For example, an outcome from the September 2018 pharmacist audit was, "Discuss particular [medicines] issues/policies at staff meetings to help keep people up to date…record the subjects discussed within [staff] training records. We asked the registered manager if this had taken place at the last staff meeting. They told us there was an agenda for the next staff meeting but that the pharmacist's feedback was not included. The registered manager said the matter "should be" placed on the agenda for the next team meeting, and that medicines management will be addressed in supervision sessions with staff.

The workplace culture amongst the staff team remained positive. Care workers we spoke with during our inspection were satisfied working at the service and did not have any concerns to raise with us. The registered manager told us they had addressed the issue of staff accessing and booking their training via an online portal. This resulted in more staff completing more training. Staff meetings took place consistently on a monthly basis since July 2018. There was a plan of the dates of the meeting on the staff office wall. The registered manager reported that they found the staff meetings "useful", that they helped workers to reflect and make suggestions and assisted to "stay on top of things". The registered manager said the more frequent meetings, "…gives staff an opportunity to air opinions [and] helps make staff feel valued." The staff meetings offered the opportunity to reflect on positive activities for people, for example when some singers visited the home. This was a good experience for people and as a result staff expressed interest in repeating this. The staff meeting was also used to deliver some key messages, for example which staff would be covering caseloads when key workers were absent.

Our last inspection rating was conspicuously displayed in the service and on the provider's website, in accordance with the relevant regulation. The statement of purpose was up-to-date. A statement of purpose is information about the registered manager, provider, aims and objectives required by law. The statement of purpose was accessible to people and others in the entrance to the service. The registered manager knew when to send required notifications to us, although they admitted failing to send two for recent DoLS

outcomes. We offered them the opportunity to submit the notifications after our inspection. We received the notifications without delay.

The service continued to maintain good links with other organisations in the local community. The connections with other agencies benefitted people, as information and practice was shared with the service. People also had access to the support provided by the external organisations.