Our TLC Limited

Redburn House

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 11 August 2015 and was an unannounced inspection. This meant the provider had no prior notice of our inspection. On the date of the inspection there were 48 people using the service. The service consists of Redburn House which provides accommodation and personal care for up to ten people with mental health needs. In addition, the provider had a separate registration for personal care which allows it to provide services in the community. Supported living services are provided at seven properties, where staff aim to support people rehabilitate and develop life skills. Domiciliary support is also provided to a small number of people in their own homes.

During our previous inspection in May 2014 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The breaches related to Records and Assessing and Monitoring the Quality of Service Provision. As part of this inspection we checked whether improvements had been made in these two areas as well as to provide a rating for the service under the Care Act 2014.

A registered manager was in place. 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.

We found the provider had failed to make sufficient improvements in the two areas where we identified

Summary of findings

breaches of regulation in May 2014. Some aspects of record keeping were now improved. For example care plans were more concise with less repetition and no blank pages were present. However documentation showed that two people's weights were not being recorded in line with the frequency set out in their care plan. This was similar to an issue identified in May 2014 showing action had not been taken to address previously highlighted risks.

We also found deficiencies in quality assurance systems operated by the service still remained. Medicine management audits were not sufficiently robust and had not identified the issues we found during the inspection. There were no audits of care plans and overall care quality despite the provider's policies showing these should be periodically undertaken.

We found the provider had not reported all required notifications to the Commission as it had failed to notify us of all allegations of abuse.

People told us they felt safe using the service and did not raise any concerns with us. Routine risks to people's health and safety were assessed in a range of areas to help staff support them to lead their daily lives in both a safe and enabling manner. However following safety related incidents, we found robust investigations were not always undertaken to review the root cause of incidents and help prevent re-occurrences.

At Redburn House, we found most aspects of the premises were safely managed. However we found no radiators at the home were covered or were of a cool panel design. We identified this meant some people who used the service were potentially at risk of sustaining a burn injury.

Medicines were not safely managed. Controlled drugs were not administered in a safe manner as one staff member was administering them with no checks or supervision from other staff. There was a lack of robust stock control measures to ensure all stocks of medicines were accounted for.

Staffing levels were sufficient to ensure people received the required care and support. We saw staffing levels allowed staff the time to interact positively and form good relationships with people.

People spoke positively about the food provided by the service. Some people were independent and could make their own food and drink and we saw these people were provided with appropriate guidance and support where required. At Redburn House a cook was employed and provided a varied menu based on people's choices and preferences.

We found gaps in staff knowledge and skill, for example around restraint and safeguarding. There were no regular checks on staff skill and knowledge to ensure they had the required skills to effectively undertake their role. Although staff received mandatory training, some of this was overdue an update. Some training was also not provided to staff despite policies stating it should be.

People's healthcare needs were assessed and clear plans of care put in place to help provide effective healthcare support. People had access to a range of health professionals.

The service had not been fully acting within the legal framework of the Mental Capacity Act as for one person a Deprivation of Liberty Safeguards (DoLS) authorisation had been incorrectly transferred from another location. However during the inspection immediate action was taken to rectify this with an urgent authorisation sought. In other cases, DoLS had been correctly applied for and the service was following the conditions of the authorisation showing it was acting within the correct legal frameworks.

We found staff and management to be dedicated to providing a caring, person centred service to the people they supported. Staff were kind and caring and treated people with dignity and respect. Care plans contained detailed information on people's likes and dislikes and the staff we spoke with knew people's preferences well. People were involved in their care and support and told us they felt listened to.

People were supported to undertake activities and live an active life with community involvement and social interaction encouraged. We found more could have been done to support people to set and achieve measurable goals relating to rehabilitation and developing life skills.

People and staff told us the management were effective and took action to address any issues. People's feedback

Summary of findings

was regularly sought through service user meetings, care plan reviews and quality questionnaires. We saw evidence the service acted on feedback to improve the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. Medicines were not consistently managed in a safe way.

People told us they felt safe using the service. We found a range of risk assessments were in place describing how staff should help to keep people safe. However following some incidents, there was a lack of investigation into how to prevent a re-occurrence.

Staffing levels were sufficient in the service to ensure people received the required care and support.

Is the service effective?

Requires improvement

The service was not always effective. We found staff did not always have the required knowledge, training and support to care for people effectively.

People's healthcare needs were assessed and they had access to a range of healthcare professionals to help them achieve or maintain good mental and physical health.

People told us they could choose what they did on a daily basis and that staff respected their choices. Documentation showed this to be the case

Is the service caring?

Good

The service was caring. People told us that staff treated them well our observations showed staff to be kind and compassionate, respect people's privacy and encourage their independence.

Staff we spoke with knew people well and their individual likes and dislikes. Care plans contained highly personalised information on people's likes, dislikes and preferences to help staff provide individualised care.

Is the service responsive?

Requires improvement

The service was not always responsive. People had a range of personalised care plans which provided clear information on how staff should meet their individual needs. We saw evidence care was delivered in line with these plans.

We found some missing information in care records such as a lack of evidence the service undertook weight monitoring at the agreed frequency.

People were supported to undertake activities and encouraged to participate in the local community. However care planning lacked the development of long term goals with people to help them achieve their ambitions.

Summary of findings

Is the service well-led?

The service was not always well led. A full range of audits and checks was not undertaken to help assess and monitor the quality of the service. Some issues identified at the May 2014 inspection had not been rectified demonstrating a lack of action in addressing risk.

People spoke positively about how the service was run. People's feedback was sought through various mechanisms including regular meetings, care plan reviews and quality surveys.

Requires improvement

Redburn House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked whether the provider had made improvements following our May 2014 inspection, where we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The breaches related to records and quality assurance

The inspection took place on 11 August 2015 and was unannounced. The inspection team consisted of two inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing care and support delivered at Redburn House. We also visited two supported living properties in which the service provided regular care and support, where we spoke with staff, people who used the service and viewed care plan documentation. We made phone calls to people who used the domiciliary service and to staff who provided this care and support. In total, we spoke with nine people who used the service, one relative, the nominated individual, the registered manager, eight support workers and the cook. We looked at six people's care records and other records which related to the management of the service such as training records, policies and procedures.

Prior to our inspections we normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the provider to complete a PIR on this occasion. We reviewed all information we held about the provider. We contacted the local authority to ask them for their views on the service and if they had any concerns.

Requires improvement

Is the service safe?

Our findings

We found medicines were not consistently managed in a safe way. During the morning at Redburn House, we observed a care worker administering medicines. We saw one person being administered dispersible aspirin without it being dissolved in water. Whilst we were told the person preferred to take the medicine this way this had not been brought to the attention of their GP or the pharmacist to ensure the appropriate form of aspirin was prescribed. Furthermore the person's care plan specifically said the aspirin had to be dissolved in water. This showed the person was not receiving their medicines in line with the prescriber's instructions. This may have reduced the effectiveness of the medicine and put the person at risk of unwanted side effects.

We conducted an audit to account for medicines dispensed in named boxes. We randomly chose four medicines and on one occasion out of the four we found discrepancies. One person had been prescribed Lorazepam and yet the medicine administration record (MAR) did not account for tablets administered. On reviewing archived MAR sheets back to April 2015 they showed at that point 14 tablets had been received. MAR sheets since then showed the medicine had been administered on eight occasions yet we found 10 tablets held in stock. Further examination of daily care records could not reconcile the stock balance. Discussion with the manager led us to the conclusion that adequate stock control methods were not in place. This meant medicines were not always accounted for and demonstrated unsafe management of medicines.

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

We saw 'as necessary' (PRN) medicines were administered with the aid of a written protocol.

During our visit we checked inside the medication cupboard. We saw it was kept in an orderly manner and medicines were stored appropriately.

We looked at prescription sheets to ascertain the frequency of use of antipsychotic medication to control behavioural issues. In discussion with care staff and the scrutiny of the MAR sheets we were assured that non-pharmacological interventions were the preferred method of addressing challenging behaviours.

The provider's medication policy stated, 'The home believes that everyone has the right to keep and administer their own medicines whenever they are able to do so,' however medication assessments were not in place assessing whether people had the ability to self-medicate. This lack of assessment was not conducive to increasing people's independence by providing them with the opportunity to self-medicate However in the community we saw better systems had been put in place to enable people self-medicate.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis.

People we spoke with told us they felt safe whilst using the service and did not raise any concerns about the way they were treated. They said if they had a concern they would go to the manager and they were confident it would be addressed. Information to guide staff on safeguarding was present throughout the service. Staff with whom we spoke demonstrated a mixed understanding of safeguarding, some were not able to demonstrate a good understanding of safeguarding issues and were unable to give examples of how they would identify abuse. However staff knew the principles of whistleblowing and assured us they would make use of whistleblowing if necessary. Staff were keen to assure us the management team had an open approach and they had confidence any concerns they had would be dealt with.

Detailed risks assessments were in place which assessed the risks to people's health and safety. We saw in each case the risk was recorded in detail. The level of risk had been determined and mitigating actions identified to reduce the risk. Some people were vulnerable to exploitation. Care plans demonstrated how to address the challenges whilst recognising the person's own wishes and ambitions showing risks in this area were well managed.

We saw all risk assessments were reviewed every three months. We asked staff about their understanding of people's risk assessments. They demonstrated a good understanding of the risks people were exposed to and they told us they gained greatest insight into people's care

Requires improvement

Is the service safe?

needs by their attendance at Care Programme Approach (CPA) meetings. The CPA is a way services are assessed, planned, co-ordinated, and reviewed for people with mental health needs or a range of related complex needs.

However we found inconsistencies in the way risks were managed. A system was in place to record incidents and accidents; however this was not always effectively utilised. We found some incidents were fully investigated with a 'manager follow up' form completed demonstrating the action taken to prevent a re-occurrence and keep people safe. However this was not consistently completed. For example we looked at two incidents, one where it had been alleged that one person had hit another, and another where a person had had hit a staff member. The follow up information was blank and there was no information added to these people's care plans to show what preventative measures were put in place. This meant risks to people's health, safety and welfare were not being effectively assessed, monitored and mitigated.

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

At Redburn House, we found no radiators at the home were covered or were of a cool panel design, this meant some vulnerable people living there were potentially at risk of sustaining a burn injury. The provider assured us the matter would be corrected. This meant risks to people's health, safety and welfare were not being effectively assessed, and mitigated.

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

As part of our inspection of Redburn House we completed a tour of the premises. We inspected five people's bedrooms, bath and shower rooms and various communal living spaces. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We saw all upstairs windows had opening restrictors in place to comply with relevant guidance in relation to falls from windows. We found all floor coverings were appropriate to the environment in which they were used. With the exception of one room, all floor coverings were of good quality and properly fitted thus ensuring no trip hazards existed. Systems were in place for staff to report building related faults and we saw evidence these were promptly actioned by the maintenance team. Checks on safety related systems such as water, gas and electric took place to help keep the building safe.

People we spoke with told us there were enough staff both in Redburn House and in the community to ensure that people's domiciliary care needs were promptly attended to. Staff we spoke also said the organisation was sufficiently staffed and did not raise any concerns. We discussed staffing arrangements with the provider. They told us at Redburn House, two care staff were the core of day-time staffing. Whilst some people cooked for themselves or cleaned their own rooms as part of a rehabilitation programme, the provider employed a cook and cleaner to ensure the needs of everyone could be met. We were told domiciliary staff supplemented the staffing requirements to ensure people could pursue community events and hobbies. We saw this in action during our visit and evidenced in daily records. Within the community, planned staffing levels were maintained at the supported living properties. People and relatives told us staff arrived on time and delivered a reliable service in their own homes. This demonstrated there was an adequate and flexible staffing resource available to meet people's needs.

The service had recruitment procedures in place. We spoke with new staff who told us they had completed an application form, attended an interview , completed a Disclosure and Baring Service (DBS) check and been asked to provide references. We reviewed documentation relating to new members of staff. These showed staff had attended an interview with questions showing a strong focus on mental health to ensure staff were suitable for a role in this area. DBS checks were in place and satisfactory evidence of conduct in previous employment. However one file we looked at did not have any evidence that the persons identify had been checked. We asked the provider to investigate this omission and they assured us it would be addressed.

Requires improvement

Is the service effective?

Our findings

People spoke positively about the staff that supported them and said they had the required attributes to support them effectively. Staff we spoke with had a good understanding of the people's individual needs we asked them about. Staff told us that they had received training in a range of areas. However we found it had not always equipped them with the necessary skills to undertake their role. Training was computer based with staff required to complete mandatory training in subjects such as safeguarding, medicines, infection control and manual handling. Following training, staff were required to complete a brief online test. At Redburn House, we found gaps in staff knowledge when we questioned them about topics such as safeguarding , medicines and mental capacity, even when staff had completed online training in some of these subjects indicating the training had been fully effective. In the absence of any formal competency assessments and supervisions in these areas, we concluded their knowledge was not being adequately monitored by the provider.

We saw the provider had a policies on restraint and managing violence and aggression . We spoke with two members of staff about the use of restraint. We found the staff had a poor understanding of the legal frameworks in which staff can operate and had an equally poor understanding as to what constitutes restraint. We found staff were unable to describe de-escalation techniques which may need to be used. Policies stated all staff were to be provided with training on managing conflict and de-escalation on an annual basis yet staff told us and records showed this was not the case. Our observations, examination of the policy and staff discussion demonstrated that potentially people may not be being protected from the unlawful use of restraint due to lack of skill and knowledge in this area.

We looked at the provider's training matrix. We were told mandatory training should be updated annually. However records showed 13 out of 30 staff were out of date or had not completed safeguarding training, and 18 staff were out-of-date or hadn't completed moving and handling training. Most staff had not completed training in Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) and we found they didn't have a good knowledge in these areas. We found although seven staff were enrolled on a mental health awareness course, only one staff had completed this despite the service providing a service to people with mental health needs. In addition the provider's file policy stated that staff would receive fire training every three months, but most staff were outstanding fire training and it was not listed as mandatory on the training matrix.

Although new staff went through a two week shadowing period, on looking through staff files we found there was no record of any local induction to confirm they had been inducted to the building, the policies and ways of working. We also found most staff had not received a recent supervision and appraisal and the registered manager told us they were behind in this area.

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

Staff had received specialist training in some areas to help meet people's individual needs, for example we saw staff had received training in a degenerative disease which affected one resident. A staff member also told us how they had received additional training in oral hygiene.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We found the provider was not fully conversant with the requirements of the act due to inconsistencies in practice. However these were rectified immediately during our inspection. We were told that two people using the service were subject to authorised deprivation of liberty. We were told both authorisation contained conditions which the providers was adhering to. We found one person who the provider believed was subject to DoLS had transferred from another home early in 2015 yet there had been no new application made to the respective Supervisory Body. The provider immediately informed the Supervisory Body and on their advice issued an urgent authorisation.

We recommend the service seek advice and guidance from a reputable source to ensure it consistently acts within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Requires improvement

Is the service effective?

The other person subject to DoLS also had in place a Community Treatment Order (CTO) under the Mental Health Act 1983. We found this DoLS to be appropriately managed, the manager was aware of the conditions of the CTO and was aware of the boundaries between the two legal frameworks. We saw evidence of close co-operation between the mental health services responsible for the CTO and the home responsible for the DoLS.

People told us they had access to healthcare services and were appropriately supported by staff. Records showed arrangements were in place that made sure people's health needs were met. Support plans contained information to help staff meet people's needs such as how to safely manage people's medical conditions. We saw evidence staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, psychiatrists, hospital consultants, community mental health nurses, social workers, and dentists.

Many people at the home were diagnosed with a severe mental disorder, were at risk of harm, may tend to neglect themselves and had a history of having being detained under the Mental Health Act 1983. As such people's care was coordinated under a Care Programme Approach (CPA). This approach ensures a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw that CPA meetings took place at the home with all relevant health and social care professional in attendance. We looked in detail at one care plan where the person had a degenerative disease. We saw the care plan had been constructed with input from specialist nurses from a specialist organisation. Furthermore we saw training had been delivered to all care staff in the key requirements of people with this illness. We observed staff caring for this person with skill and understanding.

We saw people were given choices as to how they wanted to spend their time. This was evidenced in daily records of living and showed people's choices were respected. We observed this was the case on the day of the inspection with people asked what they wanted to eat and drink. People were free to eat where they wanted such as with other residents or in the privacy of their room. Many people who used the service could cook for themselves, particularly in the community and we saw evidence they were appropriately supported when necessary by staff. Within Redburn House, a cook was employed who cooked a varied menu. People were supported to cook where they could, for example one person was on the rota to cook once a week. The menu was developed by the people who used the service through regular meetings. People we spoke with praised the food for example one person told us how much they had enjoyed the meal the night before and said the food was "always nice." Eating and drinking care plans were in place which assessed people's nutritional needs and provided staff with guidance on how to deliver appropriate care.

Good

Is the service caring?

Our findings

All the people and relatives we spoke with, both in Redburn House and the community told us that they were happy using the service. They all said staff were kind and compassionate and treated them well. For example one person told us "Like living here, really nice staff." People told us they were cared for by familiar staff that understood their likes and preferences. A relative told us "All workers are very good, they are flexible, listen to you and accommodate you."

We spent time observing the care and support provided to people at Redburn House. We noted there to be a calm and settled atmosphere helped by staff sensitive to people's needs. This helped people who had identified problems with anxiety which could result in distress behaviours. Staff spoke quietly and encouraged people to participate in conversations. During their interactions with staff people's body language showed they appeared relaxed. We saw many positive interactions noted and staff having fun and sharing jokes with people. This indicated that people were comfortable in the company of staff.

Staff respected people's privacy, for example respecting their choices to eat their meals alone in their rooms and knocking on their bedroom doors and waiting before being invited in. Where staff discussed medical or confidential subjects with people we saw this was done in a discrete manner to help respect their privacy.

Staff we spoke with demonstrated a good awareness of how to respect the people they were caring for, including listening to their choices and opinions and promoting their independence and general wellbeing. Both at Redburn House and in the community we observed staff had the time to interact closely with people and provide a high level of interaction and companionship.

We were told by the manager that the provision of care at the service was developed around the individual choices of people living at the home. This included choices around how people liked to have their bedrooms and the communal areas. People's bedrooms at Redburn House were personalised and contained pictures, ornaments and the things each person wanted in their bedroom. People told us they could spend time in their room if they did not want to join other people in the communal areas. We saw when people chose to spend the day in their room staff took time to ensure they were not isolated.

Care plans were personalised with information on people's likes and dislikes recorded. Staff we spoke with had a good understand of the people they were caring for demonstrating they had taken time to spent time with people and understand their needs. Care plans and daily records of care demonstrated that known circumstances which triggered bouts of anxiety or behaviours that challenge were well documented. Annotations in care plans showed practical interventions were carried out by staff to ensure people were not distressed which would have a detrimental effect on people's mental health.

We saw evidence people and/or their relatives were regularly involved in care reviews and their views recorded within files. Care plans were signed by the individual showing consent and involvement with regards to their support plans. People we spoke with all said they felt listened to by staff.

People's independence was promoted by the service for example teaching people how to cook and clean for themselves and allow them to manage their own care and treatment. Staff had a good understanding of how to encourage people to maintain and develop people's independence.

Requires improvement

Is the service responsive?

Our findings

People and their relatives reported that staff understood people's individual needs. They said that staff provided appropriate support in daily living for example in helping people access the gym, cleaning, cooking and taking care of themselves. People receiving domiciliary care said the service was reliable and staff visited at the right times for example one person told us; "Excellent, great service, everyday it runs like clockwork."

Support plans had been developed with each person to help staff provide appropriate care and support. These were highly personalised with individualised information on people's wishes in relation to how the wanted their care and support provided. They contained clear information on how to support people in areas such as physical health, personal care, communication. Care plans recognised the need to build long term relationships with health care professionals to minimise the need for in-patient mental health care in the future. A large part of the care plan was dedicated to supporting people to develop daily living and social skills. These plans included, building relationships, household skills, health awareness, cooking, laundry, leisure pursuits, shopping and money management. We saw examples of staff delivering care and support in line with care plans for example in assisting someone who liked to go on regular walks

However we found some areas where support plans required improvement. In two people's care plans, records showed they were not having their weight monitored at the frequency set out in the care plan. Although staff told us the people refused to be weighed weekly, this was not robustly documented. In one case, it had been highlighted that a health professional was concerned about the person putting on weight, however a clear diet plan was not in place to help support them to eat healthily.

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

People and relatives told us they had been involved in the creation and regular review of their care plan and we saw this to be the case in the records we looked at as they were signed by the person. This demonstrated the service took steps to involve people in their care and support.

The manager told us that the service aimed to help rehabilitate people and develop their life skills through care in Redburn house and in the community. People generally told us the service had been effective in helping them develop life skills. For example one person told us how they were taught to cook and clean for themselves and take care of their hygiene. They said staff supported them with activities and companionship. Another person told us how the service had helped them feel self-worth. Staff we spoke with had a good understanding of people's aspirations and how to help them achieve them. However we found there was a lack of structure to this. Care plans did not contain measurable goals to provide a structured and stepped approach to achieving goals over a period of time. This also meant there was no evaluation of whether people had achieved their goals. A relative also told us this was the only area the service could be improved, as although they felt daily living activities were good and fulfilling, there were not aware of any long term strategies to help their relative progress as an individual. The provider told us a more structured approach to long term care planning and evaluation was something they were aiming to develop in the future.

Staff told us that a handover took place each morning between shifts at Redburn House. We saw detailed handover records were maintained which provided information on people's latest activity and needs. This helped staff to provide responsive care.

People told us they felt well supported by staff and that they had helped them to do things they enjoyed. Daily records provided evidence that people were supported to socialise, doing a range of things such as shopping , going for walks and visiting the library and attending events in the community such as at a local church. People receiving care in their own homes were also supported to socialise with other people who used the service. Staff demonstrated a good understanding of what people enjoyed doing and how to support them to undertake meaningful activities.

A system was in place to manage complaints. People we spoke with told us they had no cause to complain but they would go to the manager if they needed to complain, demonstrating a high level of satisfaction with the service. Complaints were on the agenda at residents meetings to ensure people were prompted to raise any concerns. Information on how to complain and complaint forms in an accessible format were located throughout the service and

Requires improvement

Is the service responsive?

also within the service user guide given to all people who used the service to support people to complain. We saw there had been no complaints received about the service in the last year. One relative told us where they had raised minor issues “They listen and apologise if there are any issues” and said any issues were quickly sorted out.

Requires improvement

Is the service well-led?

Our findings

We found the provider had not reported all required notifications to the Commission. We looked at documentation detailing an allegation of abuse which occurred in 2014. Although it had been correctly reported to the Local Authority safeguarding team and clear measures put in place to keep the person safe, the service had failed to notify the Commission about the incident. In addition we found two further incidents of aggression between service users which occurred in 2015, which we concluded should have been reported to us as notifiable incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We wrote to the provider and warned them that we would take further action if incidents of this nature were not reported to us in the future.

At the last inspection in May 2014 we found records were not appropriately managed, for example people's care records were overly bulky and inconsistently completed. At this inspection, we found improvements had been made in some areas. Care records were now better ordered with less repetition between care plans and key information on people's support was now easy to find. This helped staff to provide appropriate care. We found care plan documentation was now better completed for example detailed information on people's biographies was now consistently recorded. However we were concerned that some issues still remained. Where people's care plans stated they should be weighed weekly or monthly, this was not always being documented. This was a similar issue that we identified in May 2014 and showed a lack of acting on feedback raised at the previous inspection.

Since the last inspection in May 2014 the service had expanded to providing supported living services and domiciliary care in people's home. We found despite this growth, systems to ensure key policies were followed and to assess and monitor the quality of the service were not yet fully embedded throughout the organisation. The provider had a range of policies and procedures in place setting out how it should operate to a consistent, high quality service. However we found most of these were overdue their review date. We found the provider was also not working to some of it's policies and procedures. For example policies on dignity & respect, fire and managing violence and aggression, stated that training would be provided in these areas but training records showed this had not happened or not at the frequency set out in the policies.

Some systems were in place to assess and monitor the quality of the service. Regular infection control audits were conducted at Redburn House and we saw these were identifying issues. Medication audits were undertaken, however these were not sufficiently robust, as we found several risks associated with medication which had not been identified by the provider. Medication audits just stated that "everything had been checked" for each service user, rather than using a standardised format to scrutinise individual elements of the medication management system. Care plan audits were not undertaken, despite the Commission raising this as an issue during the May 2014 inspection, showing the service had not appropriately acted on feedback. An overall audit of quality did not take place despite the provider's policy stating it would.

Recruitment checklists were not properly completed in the front of personnel files. We found inconsistencies in the presence of documentation such as presence of health questionnaires and identify documents which could have been identified had the proper checklist been completed. This showed that this element of the service was not being adequately assessed and monitored.

In addition, we found gaps in some staff skill and knowledge for example around medication, Mental Capacity and safeguarding. Although training was provided in some of these areas, there was no system to monitor staff skill and knowledge and supervisions and appraisals were behind schedule.

We also concluded more work was needed by the provider to monitor the quality of care and documentation in the community part of the service. The domiciliary part of the service had been operating for six months. There was not an adequate system in place to check records of care to ensure that people were receiving the required level of care and support. Most records from the last few months had not been brought back to the office which meant there was no check on the tasks undertake and the timing of visits. We saw this was something the provider was planning to address through a new system of recording daily care activities, however this was not in place at the time of our inspection.

Requires improvement

Is the service well-led?

Although accidents and incidents were recorded, completion of lessons learnt and manager's actions was not robustly completed. There was no system in place to analyse the number of accidents and incidents and for example categorise trends such as falls, violence and aggression or number of incidents occurring in community in people's homes and supported living properties. This risked that key trends and patterns would not be identified and acted upon to reduce risks and re-occurrences.

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

People who used the service told us the service was well run and they praised the service and the management team. They said the management team were friendly and approachable and listened to them. Staff we spoke with told us they felt well supported by management, and told us they were effective in dealing with any problems. An on call system was in place to ensure management support was available to staff at all times.

During our observation of care in Redburn House and the supported living properties we observed a pleasant and calm atmosphere with good positive interactions between staff and people who used the service. When we spoke with staff they demonstrated a dedication and motivation to providing a high quality caring service with the people they supported at the centre of their work.

The service had robust systems in place to seek people's feedback on a regular basis and use it to improve the service. Regular reviews were undertaken with people where their views on the care and support they were receiving were discussed. People and relatives told us these were useful and they felt the service acted on their feedback. At Redburn House, satisfaction questionnaires had been completed by people who used the service. We saw where these had identified issues , improvements had been made to the provision of the service. Domiciliary community services had only been running several months and as such the provider had not yet asked people to complete a questionnaire . However informal feedback methods such as telephone calls and feedback from staff visiting people had been used and the people who used this service reported that they felt listened to by management.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risk of unsafe management of medicines. Risks relating to the premises were not appropriately controlled. Care and treatment was not provided in a safe way as the service had not assessed and mitigated risks to people's health and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not always supported by staff who were suitably competent and skilled . Training, supervision and appraisal was not consistently completed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processed were not being operated effectively to assess, monitor and improve the quality and safety of the service. Systems and processes were not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. A complete record in respect of each service user was not in place.

The enforcement action we took:
We issued a warning notice to the provider requesting they make improvements by 20 November 2015.