Pathway Healthcare Ltd

Magellan 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**

Summary of findings

Overall summary

The inspection took place on 25 October 2017 and was announced. Magellan House provides accommodation and personal care for up to nine people specialising in care for young adults with autism and learning disabilities who have communication and positive behaviour support needs, nine people were supported at the service on the day of our inspection and were aged from 18 to 30 years. They required support with personal care and had additional communication needs. Accommodation was arranged across two floors of a large house. The service is one of three residential care homes run by Pathway Healthcare Ltd, a specialist provider of care, support and housing services.

The service had a registered manager. A registered manager is a person who has registered with the CQC 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 home is run.

The provider was not consistently working within the principles of the Mental Capacity Act 2005. Mental capacity assessments were not in place to demonstrate whether people could consent or not consent to the use of restrictive practice. Accurate, complete and contemporaneous records had not been maintained.

Statutory notifications had not been routinely submitted to CQC by the provider. A notification is information about important events which the provider is required to tell us about by law. A quality assurance framework was in place but this had not always been effective in driving improvement and identifying shortfalls.

The management of medicines was not safe and the administration of medicines was not always undertaken in a safe manner. Staffing levels were maintained with regular use of agency staff, however, the provider could not consistently demonstrate that agency staff had the right training and skills to provide safe and effective care.

Safeguarding procedures were in place and where required the provider had raised safeguarding concerns. However, steps had not been taken to ensure that any outcomes of safeguarding enquiries had been met. Systems were not consistently safe in ensuring that people were protected from the risk of improper treatment. People were at risk of not always receiving personalised and responsive care.

Staff told us they worked as part of a team, that the service was a good place to work and staff were committed to providing care that was centred on people's individual needs. There was a strong caring culture in the care and support team.

People were supported to maintain good health through regular visits with healthcare professionals, such as GPs, dentists and the specialists involved in their specific healthcare needs.

Staff treated people as individuals. Staff were knowledgeable about people's likes, dislikes, preferences and care needs. They approached people in a calm, friendly manner which people responded to positively. Relatives spoke highly of the service. One relative told us, "They couldn't be in a better place."

People were encouraged to lead active lives and were supported to participate in community life where possible. People were empowered to access support from a range of services and staff worked alongside these organisations to support people when required.

There were sufficient numbers of staff to meet people's needs and to keep them safe. The provider had effective recruitment and selection procedures in place. Relatives confirmed that they felt their loved one was safe living at Magellan House. People, relatives and staff spoke highly of the registered manager. One staff member told us, "The manager is so lovely and approachable."

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Magellan House was not consistently safe.

The management of medicines was not consistently safe. Systems were not consistently robust to protect people from improper treatment.

Robust systems were in place to check staff were suitable to work in the service. Safeguarding policies and procedures were available and staffing levels were organised according to people's needs.

Is the service effective?

Requires Improvement

Magellan House was not consistently effective.

The requirements of the Mental Capacity Act 2005 were not always followed. Staff did not always receive training in key subjects to enable them to carry out their role effectively.

People's health needs were met in conjunction with a range of specialist and community services.

People's nutritional needs were met and staff promoted independence with meal preparation. Systems were in place to support staff and staff received regular supervision

Is the service caring?

Good

Magellan House was caring.

Staff knew the people they supported well including their preferences, likes and dislikes.

People were able to make their feelings and needs known and were treated with dignity and respect.

Staff were kind and caring in their approach with people, supporting them in a kind and sensitive manner.

Is the service responsive?

Requires Improvement

Magellan House was not consistently responsive.

The service was not consistently responsive to people's individual care needs.

Staff supported people to develop their daily living skills and to maintain relationships that were important to them. People were listened to and their comments acted upon.

People led busy lifestyles with access to a range of meaningful activities which were tailored to individual needs.

Is the service well-led?

Requires Improvement

Magellan House was not consistently well-led.

The provider had failed to notify the Commission of specific events. The systems in place to ensure people consistently received a good and safe service had not been effective. Accurate, complete and contemporaneous records had not been maintained. Further work was required to embed and sustain positive changes.

Staff and relatives spoke highly of the registered manager and their leadership style. Staff were encouraged to feedback on the running of the service

Magellan 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 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 inspected Magellan House on the 25 October 2017; the inspection was announced. The provider was given 24 hours' notice because the location is a small care home for people with autism, autistic spectrum disorders and learning disabilities with positive behavioural support needs. We needed to be sure that people would be available and that our presence would not unsettle them or their routines. This inspection was brought forward due to a safety incident at the service. The inspection was carried out by one inspector, a specialist nurse advisor with experience of positive behavioural support 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.

Before the inspection we checked the information that we held about the service and the provider. The provider had completed 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. This included previous inspection ratings and statutory notifications sent to us by the registered manager that tells us about incidents and events that had occurred at the service. A notification is information about important events the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spent time with people who lived at the service. We spent time in the lounge and dining room. We took time to observe how people and staff interacted. Some people were unable to use structured language to communicate verbally with us, so we took time to observe how people and staff interacted throughout the day. We spoke with two visiting relatives, the managing director, the registered manager, four people and four care staff.

We reviewed three staff files, five care plans and associated risk assessments, four weekly staff rotas, medication records, policies and procedures, health and safety files, compliments and complaints

recording, incident and accident records, quality monitoring documentation and meeting minutes. We also looked at the menu and weekly activity plans.

This was the first inspection of the service with the CQC.

Requires Improvement

Is the service safe?

Our findings

Due to communication needs, not everyone was verbally able to tell us if they felt safe living at Magellan House. Observations demonstrated that people responded to staff with smiles and hugs. Observations demonstrated that staff provided a reassuring presence along with support and guidance when needed. Relatives also confirmed they felt confident that Magellan House provided a safe and secure environment for their loved ones. One relative told us, "I am confident leaving my family member here. It is the right place for them to live and learn life skills. The behaviour of my family member has improved since they have been living here." However, despite these positive comments, we observed areas of care which were not consistently safe.

The management of medicines was not consistently safe. Guidance produced by the National Institute for Health and Care Excellence (NICE) advises of the importance of the six 'rights' of administering medicines. These rights include right person, right medicine, right time, right route and right dose. We observed the administration of medicines and found that the six 'rights' were not consistently adhered to. For example, the staff member administering medicines failed to check the dose of the medicine they were administering against the recorded dose on the Medication Administration Record (MAR) chart. One medicine they were administering was subject to tighter legal controls because of the risk of misuse. However, before administering this medicine, they failed to check the stock balance to ensure that it matched what was recorded. During the administration process, the medicine had been left on top of the medicine trolley which was unlocked. The staff member left the medicine room which was locked but left the medicine out in a pot on top of the medicine trolley and left the medicine trolley unlocked. The action of leaving the medicine out and the trolley unlocked went against best practice guidance produced by 'NICE' which advises on the importance of medicine trolleys remaining locked when left unattended. This also posed a risk due to a recent incident at Magellan House whereby a person locked themselves in the medicine room.

Guidance produced by the Royal Pharmaceutical Society advises that 'it is mandatory for all health care professionals to maintain a running balance of medicines that are subject to tighter legal controls'. We reviewed the balance of these medicines against what was recorded in the provider's medicine register and found a number of discrepancies. For example, the balance for one medicine did not match what the provider actually had in stock. The recording for one person reflected that the balance of one of their medicine had reduced despite that medicine not being administered. A member of the management team later advised that the discrepancy was due to the person returning home and the medicine being taken home with them; however, this was not reflected in the provider's medicine register. The provider's internal medicine audit had failed to identify this shortfall.

People had individual medicine care plans in place which identified if they required support from staff to administer their medicines. However, medicine care plans failed to include guidance on the types of medicines people were prescribed, the reason for their administration and any possible side effects. There was also limited guidance for staff. For example, we asked one staff member about the medicine they were administering and they believed it was to help with anxiety. The purpose of the medicine administered was to manage the person's attention deficit hyperactivity disorder (ADHD). The MAR chart for one person

identified that they were administered a medicine in relation to their ADHD and this was prescribed for morning and lunchtime administration but also to be administered when required. Documentation reflected that staff were administering this medicine on an 'as required' basis and had done so for three days in a row. The reason for administration was due to anxiety. However, the purpose of the medicine was not to manage anxiety and a side effect of the medicine included anxiety. We brought these concerns to the attention of a member of the management team who advised that the person asked for this medicine to calm their anxiety but agreed to seek a medicine review.

A recent incident form dated 6 October 2017 stated that a person's medicine was left out (in a dispensing pot) in the clinical room for another staff member to dispense although the MAR chart had been signed to indicate that the medicine had been administered. The medicine was then left out overnight. The subsequent enquiry found that no harm had occurred to the person but did not indicate the seriousness of leaving medicines out.

Failure to provide safe medicine management is a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) 2014.

Care and support was provided to people who could display behaviours which challenge. One staff member told us, "We support people who can push boundaries, display verbal aggression alongside the challenges of people living together and taking each other things and that can then escalate. However, we focus on distraction and de-escalation to manage these behaviours." Another staff member told us, "We minimise the use of physical intervention and since I've started working here, I've never had to use. We always use distraction first, guide the person away from the situation and I would only use safe hold (physical intervention/restraint) if all other methods have been exhausted and there was a threat of violence." People's care plan included strategy behaviour plans which included guidance on behaviours which may indicate early warning signs of the person becoming agitated or stressed or behaviours during crisis point. Documentation confirmed that the use of safe holds were not conducted on a regular basis and staff confirmed that de-escalation techniques were favoured and regularly used to manage behaviours which challenged. However, despite positive aspects of risk management, a safeguarding concern had been raised regarding concerns whereby a person was restrained in a potentially unlawful manner.

Documentation reflected that an incident occurred whereby staff members were removing a person from a situation to promote the safety of other people living at the service due to the challenging behaviours they were displaying. Training records demonstrated that out of the staff involved, only one staff member had received training on the use of safe holds and the use of the safe hold conducted was not undertaken in line with recognised practice causing harm to the person. Robust systems and processes were not established or operated effectively to ensure that staff had the appropriate skills, competency and training to provide safe care and support. Documentation reflected that only five staff members out of 13 had received training on the use of safe holds. Following a safeguarding incident, the provider had changed who provided training on the safe use of restraint and staff were in the process of receiving that training. Documentation confirmed that all staff members had received online training but only three staff members had received face to face training with the new provider. The provider had recognised that the previous training was not robust, however, this posed the risk that staff had not received sufficient training on the use of safe holds, breakaway techniques and de-escalation techniques.

Guidance produced by the Department of Health advises that 'individualised support plans must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.' People had individual strategy behaviour care plans in place but these failed to consistently demonstrate when and why physical and restrictive intervention may be required. There was also no

evidence of involvement from the person to demonstrate whether they understood the need for physical and restrictive intervention.

People were not always protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Staff files demonstrated that robust selection and recruitment practices were undertaken when new staff were recruited, this included an application form with full employment history, proof of identity and evidence of the formal interview. Two references and a Disclosure and Barring service form (DBS) were taken before new staff began employment. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Staffing levels were assessed in line with people's needs and were adjusted when the needs of people changed to ensure their safety. Following incidents and safeguarding concerns, the management team considered the deployment of staff and staffing numbers. A member of the management team told us, "To ensure safe deployment of staff we utilise the staff allocation sheet which states which staff will be supporting who and that enables us to ensure people who require regular monitoring and supervision receive that level of support." Staffing levels consisted of six care staff during the day. For staff members were on duty during the evening and two waking staff at night. Staff confirmed that staffing levels had recently increased following a safeguarding concern. Where people required one to one care this was provided and agency staff were being used to cover staff shortages. Staff members felt staffing levels were sufficient. One staff member told us, "We could always do with an extra pair of hands but what service doesn't. We manager well with the staffing numbers and we always ensure that people go out and about." Visiting relatives felt staffing levels were sufficient and our own observations supported that there were sufficient numbers of staff available.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building had been assessed and people had personal evacuation plans (PEEPs) in place.

Staff had received training on safeguarding adults and recognised their responsibilities as staff members to raise any concerns or report potential safeguarding incidences. Training records confirmed staff had received safeguarding adults training and one staff member told us, "If anything came to my attention whereby people had been harmed or exposed to harm, I would raise a safeguarding concern." The provider was open and transparent following safeguarding concerns and raised safeguarding concerns in line with West Sussex County Council's multi-agency safeguarding policy and procedures.

Requires Improvement

Is the service effective?

Our findings

Relatives spoke highly of the service and staff's abilities to meet their loved one's care needs. One visiting relative praised the service and staff's ability in meeting their loved one's needs and supporting them to settle at Magellan House. One relative told us, "I can't speak highly enough of the staff. I feel confident in their ability to care for my family member. The care is amazing. The staff have a real passion." However, despite the positive feedback we received, we identified an area of practice that needs improvement.

There was a risk that people's legal rights were not fully protected as the principles of the Mental Capacity Act 2005 (MCA) were not comprehensively followed. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received training on the MCA and understood the importance of gaining consent from people and empowering people to make their own decisions. However, where people were unable to make specific decisions, the provider had not consistently worked in line with the principles of the Act. For example, the service had a Facebook page where photographs and videos of people were posted for family members to view. Where people were unable to consent to the use of their photographs being posted online, relatives had signed consent forms. Where relatives had given consent, the provider had failed to confirm that they had the correct legal authority to do.

Restrictive practice was in place for some people which included the use of monitors (devices in people's bedrooms to alert staff to any movement or if they get up out of bed). Documentation failed to reflect whether people consented to the use of monitors or whether they lacked capacity to consent to the use of monitors and they were implemented in the person's best interest. One person's care plan stated that their access to a fizzy drink should be restricted, however there was no information to reflect if the person consented to this agreement or whether they lacked capacity and this decision had been made in their best interest. The registered manager acknowledged this was an area of practice they were focusing on. However, in the interim the provider was unable to demonstrate that the use of monitors was lawful and the least restrictive option.

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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to deprive people of their liberty had been submitted and on the day of the inspection, three people's application had been authorised. Steps had been taken to recognise that people were deprived of their liberty, however, the care planning process failed to identify how care could be provided in a least restrictive option.

Failure to work within the principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff completed training that the provider considered mandatory. Training included equality and diversity, safeguarding, learning disability induction, epilepsy awareness and supporting people with autism. Upon commencing employment with the provider, staff received an induction to the service. This included shadowing other staff and completing the Care certificate. The Care Certificate had been introduced for new staff as part of their induction. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standards of care that care homes are expected to uphold. Staff spoke highly of the induction they received. One staff member told us, "The induction was good as on the second day I was gradually introduced to people so they could get to know me and I could get to know them." Additional training was also provided which included training on the use of restraint and face to face medicine training. However, documentation reflected that not all staff had received face to face training on the use of restraint and how to restrain people safely. We have discussed the associated risk of lack of staff training in the 'Safe' section of the report.

Guidance produced by Skills for Care documented that, 'effective supervision is key to delivering positive outcomes for all people who use social care. All organisations therefore need to make a positive, unambiguous commitment to a strong supervision culture.' Systems were in place for staff to receive regular supervision and staff confirmed they felt supported within their role. One staff member told us, "I'm being supported to obtain my level two and three National Vocational Qualification (NVQ) which I'm enjoying completing." Staff spoke highly of the training provided. One staff member told us, "I'm trying to do as much training as possible as it is all interesting."

Due to staff shortages and vacancies, agency staff were being utilised to maintain staffing levels. Before an agency staff member worked at Magellan House, the registered manager was a sent a profile of the training they had completed and evidence of their DBS. However, these profiles failed to include evidence that the staff member had received training in the specialist needs of people living at Magellan House including challenging behaviour and physical intervention training. We have discussed the associated risks of agency staff not having relevant training in the 'Well-Led' section of the report.

People were supported to have enough to eat and drink. The kitchen was readily accessible for people to access and cupboards were visually labelled to enable people to access items independently. Items that posed a risk such as knives were safely locked away within the kitchen. People were actively involved in meal preparation and staff regularly supported and encouraged people to be independent with making hot drinks and light snacks. One staff member told us, "If someone asks for a hot drink, unless there's a safety issue, I'll say, let's go in the kitchen and make it together. I'll encourage them to talk me through what we need to do and how we do it." Nutrition care plans were in place which considered any dietary requirements alongside people's dietary likes and dislikes. Visual information was also available within the kitchen on how people preferred their tea and coffee. For example, if they liked milk and sugar. One person told us, "The food here is very nice." Where required, people's weight was monitored for any unexplained weight loss. Staff recognised that moving into a new service and living with different people could impact on people's nutrition and hydration needs. The registered manager told us, "When people move into the service, we weight them weekly to monitor for any unexplained weight loss. Where people have lost weight, we have liaising with their families and the GP to establish if there are any other reasons for the weight loss."

Staff worked in partnership with external health care professionals to meet people's health care needs. People had access to a range of health care professionals including GPs, district nurses, Social Workers and psychologists. 'My Care Passports' were in place which included important information on people's health care needs, medical conditions and support required with medical interventions. For example, one person's 'care passport' identified that they required a staff member to attend all medical appointments and interventions with them and they preferred to have blood tests done at the service. A member of the

management team told us, "We've received some recent guidance and input around developing care passports and we will soon be rolling out 'health assessment booklets' for people. These will guidance on when people last had their eyes checked and any questions they might have when they next attend an optician's appointment." Staff recognised that medical interventions such as the flu jab could be a distressing experience for people and told us of the steps they took to calm and ease the person's anxiety. For example, staff used music and singing aloud when travelling to the flu jab appointment to help ease one person's anxieties.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff interacting with people living at Magellan House in a manner which was kind, compassionate and caring. Staff adapted their communication style to meet the needs of each person and it was clear that staff had spent considerable time getting to know people.

People were not always able to tell us about their experiences. We observed that people had good relationships with staff members and they were happy and comfortable in their presence. Staff had developed positive relationships with people. With pride, staff spoke to us about people's likes, dislikes and how they supported people. One staff member told us, "One person I support is so loveable. They are so much and we have such a giggle together. They love music and dancing and in the morning when we are driving we do car karaoke and quizzes where we have to guess the name of the song." People's care plans included an overview page which included information on what people liked and admired about the person. What made the person happy and how the individual wished to be supported. For example, one person required staff to provide structure and boundaries.

Care was delivered by staff in a patient, friendly and sensitive manner. We observed and listened to interactions between people and staff throughout the duration of our inspection. We saw numerous examples of positive and caring interactions. Where required staff provided clear instructions and boundaries which people responded to in a positive manner. Staff took time to talk with people, addressed them by their preferred name and followed practice that was caring and supported the value of dignity. For example, during the inspection, we asked for a tour of the service. A member of the management team asked a person if they would like to come on a tour with us and show us their bedroom. The warmth, inclusiveness and integrity demonstrated in the exchange demonstrated the caring values seen throughout staff's interactions.

People's bedrooms were spacious, in good decorative order and had been personalised, for example with photographs, sensory items and art. This helped to create a familiar, safe space for people. People told us how they involved in the design of their bedroom and were supported to choose the colour of the wall and the furniture they wanted. One person spent time with the inspection team showing us photographs of their family members and important events within their life. Guidance produced by the National Institute for Health and Social Care Excellence (NICE) advises that sensory stimulation for those living with a learning disability can promote quality of life. Staff understood the importance of sensory stimulation alongside people's needs for quiet and private time. During the inspection, one person was observed enjoying the quiet space that the service's sensory room provided.

People were able to maintain relationships with those who mattered to them. Relatives visited throughout the day and staff commented that there was no restrictions on times and relatives were offered meals if they wished to eat with their loved one. Staff told us that they supported people to maintain contact with their relatives and friends and supported people to buy birthday cards when required. People's care plans included guidance on people's family circle and important dates for them to remember.

People were able to maintain their identity as young adults; they wore clothes that reflected who they were as a person and activities of daily living and interactions with staff evolved around their sense of identity and purpose. People's privacy and dignity was respected. Staff respected people's right to privacy. Staff were also observed knocking on people's doors before entering, to maintain people's privacy and dignity. Where people's dignity was compromised, staff provided discreet and sensitive support to the person to enable them to maintain their dignity. Information held about people was kept confidential. Records were stored in locked cabinets and offices.

Staff celebrated people's successes and events that were important to them. On the day of the inspection, it was somebody's birthday and staff had organised for them to go out that evening to celebrate. A present had been brought and the registered manager was asking for people to save them a slice of pizza so they could also enjoy pizza in the morning. The registered manager told us, "When people move into the service, we send out a questionnaire which considers what Christmas looks like to them and other events as everyone celebrates different events in different ways. Care plans also considered what people would like on their birthday. One person's care plan noted that they would like a 'big cheesecake.'

Staff supported people in a dignified and respectful way and this was embedded within their daily interactions with people. We saw regular, positive interaction between people and staff. We heard staff taking time to explain what they were doing clearly to people in a way that promoted inclusivity and understanding. Staff kept up a friendly enquiring dialogue with people enquiring how they were. One person presented as low in mood and staff recognised immediately they were not themselves. Staff enquired if they were sad and why they were sad. Through engaging with the person they were able to establish how the person was feeling and provided support to alleviate those feelings.

Requires Improvement

Is the service responsive?

Our findings

People received individual support to access the local community and engage in a wide range of activities. Individualised weekly activity planners were in place which demonstrated that people lived meaningful and active lives which met their social, emotional and psychological needs. Relatives spoke highly of the opportunities available for their loved one to participate in and access. However, despite these positive comments, we found areas of care which were not consistently responsive.

Incidents and accidents documentation reflected a number of incidences occurred whereby an individual did not consistently receive responsive and personalised care. For example, recent documentation reflected a small number of incidences whereby a person's dignity was compromised and insufficient processes and systems meant this person did not consistently receive personalised care which promoted their well-being and ensured that staff could provide care that met and supported their individual needs. We have identified this as an area of practice that needs improvement.

Initial assessments were undertaken before people moved in to Magellan House. The assessments recorded people's support needs such as their medication, behaviour and personal care, which ensured the service, could meet their needs. During the move in process, people were provided with a pictorial book providing guidance on the move to Magellan House, what their bedroom would look like and what would happen step by step. Following the pre-admission assessment, care plans were devised. The aims of the care plan included for the team to work consistently in their approach, to provide a safe environment and to work towards improving the quality of life for the individual. Care plans covered a range of areas from medication, eating and drinking, maintaining relationships, behaviour and personal care. Care plans considered area of need and aims and objectives. For example one person's area of need included support for them to sleep undisturbed at night. Aims and objectives include for staff to complete two hourly checks at night to ensure the person was safe.

People' care plans reflected their life history, what was important to them alongside their personal preferences. One person's care plan identified that they required staff to always explain what was happening and that provided them with comfort and reassurance. Personalised information was reflected within people's care plans which provided clear guidance for staff to follow. For example, one person's personal care plan identified that they enjoyed laying down in the bath and enjoyed staff rubbing shampoo into their hair saying 'tickle tickle.'

People were supported to pursue social interests and activities that were important to them. Individual weekly activity planners were in place which were personalised to people. The registered manager told us, "We have personalised activity planners in place which are based on people's likes and hobbies, however, activities are flexible. For example, one person might be going swimming and other people may want to go along." Staff told us that people were supported to engage within a range of activities and hobbies. One staff member told us, "Yesterday we went to the cinema and then to Nando's and the other week we got the train to Thorpe Park which the person loved." On the day of the inspection, people were supported to engage in a range of activities and trips out. One person told us they were going into Brighton to do some

shopping. They told us, "I love shopping." Another person was supported to go and buy some Halloween makeup and a Halloween costume. They later proudly showed off their costume and enjoyed scaring staff.

Support was in place for people to access the local community. People attended local schools and colleges within the area. Staff also supported people to access local events within the area. For example, on a Monday some people attended a local horse sensory session whereby they spent time with horses. A staff member told us, "It is really interesting as it is all around breathing, so when the person breathes in the horse stops walking. However, where some people don't engage in activities or clubs, we always source something else they enjoy." Staff supported people to go swimming, to local pubs and going out and about on trains. One person's weekly activity timetable reflected that they enjoyed going out on train rides weekly.

People were supported to increase their daily living skills based on their individual capabilities. One staff member told us, "We always encourage independence. We encourage people to clean their bedroom and make their bed." Another staff member told us, "We support young adults here, so cleaning and tidying isn't always top of their priority but we do encourage independence." During the inspection, staff were observed asking people if their bedrooms were tidy and encouraging people to return their plates to the kitchen. On the day of the inspection, staff had brought a number of pumpkins and decorations and the registered manager was observed encouraging people to decorate the home ready for Halloween.

People were routinely listened to and their comments acted upon. Staff were seen spending time with people on an informal, relaxed basis and not just when they were supporting people with tasks. Staff assessed if people were happy as part of the everyday routines that were taking place.

Pictorial information of what to do in the event of needing to make a complaint was displayed in the service. For people who could not access written or pictorial procedures staff told us that they observed their interactions and body language and would report any concerns to the registered manager. Documentation also confirmed that during one to one sessions with people they were asked about how they would make a complaint. For example, one person commented that they would make a complaint to their key-worker and were also asked what they would do if their complaint was about their key-worker. Nine complaints had been received since July 2017. Records showed that these had been acted upon in line with the provider's procedure. Learning had been derived from the complaints and improvements made. For example, two complaints the provider had received raised concerns over staff's working patterns and lack of activities in the evening. Based on these complaints, the provider changed the shift patterns of staff to ensure staff were available within the evenings to support people to engage with activities.

Requires Improvement

Is the service well-led?

Our findings

Staff, people and their relatives spoke highly of the registered manager. One staff member told us, "The manager is so lovely and approachable." Visiting relatives also praised the leadership style of the registered manager and spoke highly of communication within the service. Whilst all feedback about the management was very positive we found the leadership of the service was not effective in all areas.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. These include events such as serious injuries, safeguarding and deprivation of liberty safeguards. The registered manager had not consistently notified us of all safeguarding concerns. Failure to notify CQC of important events is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The provider had systems in place to regularly assess and monitor the quality of service people received. However, these systems were not consistently effective in identifying shortfalls and driving improvement. For example, where people had limited verbal communication, care plans failed to include a robust communication guide or 'communication passport.' Staff members were able to advise how they communicated with people and during the inspection we observed staff engage with people via a range of forums including simple sign language. One staff member told us, "If one person hits their head that's a sign that they are in pain." Staff recognised people's various forms of communication; however, this was not reflected within care plans. A member of the management team told us, "Moving forward we want to implement communication care plans in pictorial format which includes pictures on how the person may communicate if they are unhappy or sad and clearly reflect the different ways they communicate to with us."

Guidance produced by NHS England advises that 'supporting people to be actively involved in their own care, treatment and support can improve outcomes and experience for people." People's care plans failed to reflect any involvement from people and their relatives. Documentation failed to identify if people consented to their care plan and whether they had been involved in the design and formation of the care plan. A number of the people living at Magellan House had recently left school or only had a year left of school. The registered manager told us, "We are working with people at such an exciting time of their lives. We will be supporting them to consider part time work and what they want to do." Guidance produced Social Care Institute for Excellence (SCIE) advises that 'adopting a person-centred approach means helping people to work out what they want, what support they require and how to get it.' The management team confirmed they would focus on goal setting and supporting people to achieve personal goals, however, identified this was an aspect of people's care they had not yet explored.

A number of young people living at Magellan House could on occasions become upset, anxious or emotional due to their complex needs. People had a behaviour and support strategy in place and these followed a traffic light system with guidelines for staff at every stage. For example, amber included early warning signs and strategies for diffusing and avoiding escalation of behaviour which challenges. However, these behaviour and support strategy plans were not based on a functional assessment of the person's behaviour and did not target aspects of a person's behaviour and therefore did not have any skills around

teaching replacement behaviour. Whilst the behaviour and support strategy plans were descriptive, it was not clear when they should be implemented at each stage and how they could be measured for effectiveness.

Risk assessments were also in place for behaviours such as aggression, however, following incidences of aggression, risk assessments and protocols were not consistently reviewed to assess whether they remained effective , safe or if the protocol was no longer working. For example, Antecedent-Behaviour-Consequence (ABC) Charts reflected one person was having regular altercations with another person and on the 15 October 2017 there was an incident whereby they were trying to climb the fence, screaming and slamming doors. However, following these incidences their risk assessments had not been reviewed to consider if the strategies and protocols in place were working and remained effective. A member of the management team told us, "They were most likely reviewed but we have haven't evidenced that." Positive risk management was also not consistently reflected within people's risk assessments. Staff told us how they had implemented a strategy with one person which encouraged them not to push boundaries, however, this strategy was not documented within their care plan. This posed a risk for agency staff members that they would be unaware of effective strategies when faced with challenging situations.

On the day of the inspection, a registered manager was in post. The service employed 16 members of staff some of whom were employed on a part time and bank basis. Steps were being taken to recruit staff to staff vacancies and to cover staff shortages agency staff were being utilised. The management team told us that the service tried to use the same agency staff when they needed to cover shift to provide continuity of care. They told us that when requesting agency staff they requested that staff had training in learning disabilities and behaviours that challenged. We sampled a range of profiles for agency staff that had worked in Magellan House in the past six weeks. Profiles demonstrated that some agency staff had received training on challenging behaviour but not all agency staff had. Profiles also failed to demonstrate whether staff had received on physical intervention. Documentation reflected that agency staff had been on duty during times when people displayed behaviours that challenged such as verbal and physical aggression. The provider was committed to maintaining safe staffing levels and until all vacancies had been recruited too, the use of agency staff was required. However, consistent steps had not always been taken to ensure that agency staff had the required training and skills to meet people's individual care needs.

A safeguarding policy was in place and the provider was open and honest following any safeguarding concern. However, following specific safeguarding concerns and incidents, actions had not consistently been followed or implemented. For example, one safeguarding concern was raised whereby a person was found in another person's bedroom. An outcome of the safeguarding concern included the implementation of a social storybook with the person involved (social stories can help people living with autism to develop greater social understanding of situations and stay safe). This outcome had not been actioned by the provider; the person's care plan had also not been reviewed following the safeguarding concern to ascertain whether strategies in place remained effective or whether they required reviewing.

The provider's quality assurance framework included visits from an external auditor who visited the service every three months and conducted an audit based on CQC's key areas. For example, the external audit considered safety, whether the service was effective, caring, responsive and well-led. The latest audit from September 2017 found that information regarding completed mental capacity assessments were not available. Despite, this shortfall being identified from an external audit, steps had not been taken to ensure the principles of the MCA 2005 were being adhered to. Incidents and accidents were reviewed on a monthly basis. This monthly review considered the number of incidences and accidents, strategies in place and outcomes for the service. However, the review failed to monitor for any trends, themes or patterns. For example, in incident and accident documentation from October 2017 reflected on two occasions that a

person was found to be kicking out at staff and people. However, the review of incidences and accidents failed to identify any triggers for this behaviour or any actions required to manage that behaviour.

The above evidence shows that the systems or processes in place were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and the registered manager spoke with compassion and dedication about working at Magellan House. The registered manager told us, "I've been here since the beginning and I view the service as my baby. I never imagined that when we opened the opened service late last year that we would be full now. We've faced challenges along the way and a key challenge has been nine people all with different personalities moving in together and getting to know one another. However, the strength of the service is the guys that live here. We have a great atmosphere here and it is people's home which we pride ourselves on." A staff member told us, "It's a happy home and the care is second to none. I come into work as I want the people living here to have a purpose and feel happy and know that they are wanted."

Systems had been implemented to involve staff, relatives and people in the running of the service. Satisfaction surveys had recently been sent out and the provider was in the process of collating all the results to analyse and feedback on. Staff meetings were held to provide opportunity for open communication. Daily handover meetings helped ensure staff had accurate and up to date information about people's needs and other important information.

The registered manager took an active role within the running of the service and had good knowledge of the staff and people who lived there. There were clear lines of responsibility and accountability within the management structure. A member of the staff told us, "On shift there is usually a team leader who I can report into or the registered manager. There is also the managing director who we can contact."

Staff understood the vision and values of the service and the person centred environment and culture the provider was creating. Our observations showed this was put into practice by staff during the inspection. Staff interacted with people in a meaningful and personalised manner. Laughter was heard throughout the inspection. Staff felt supported and valued and said there was a good team ethos of working together.

Magellan House opened in March 2017 and over recent months, relatives had sent the provider and registered manager a range of compliments regarding the running of the service. One compliment noted, 'I just wanted to say thank you so much for making my loved one so happy. It is lovely to see them so happy.' Another compliment included, 'To the staff, we cannot express our gratitude enough for what you do for our relation.'

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant persons. The provider had failed to act in accordance with the 2005 Act. Regulation 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a). The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment. Systems and processes were not established or operated effectively to prevent abuse of service users. Regulation 13 (1) (2).

The enforcement action we took:

We served a warning notice.