Lansdowne Care Services Limited

1 Lansdowne Road

Inspection report

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21 February 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

1 Lansdowne Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 14 people in one adapted building. At the time of our inspection 13 people were living at the home.

We checked to see if the care service had been developed and designed in line with the values that underpin 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. The registered manager did not have good knowledge of this guidance, and this was reflected in our findings during this inspection.

At our previous inspection in August 2015 we rated the service as 'good' in all five of the questions we ask. At this inspection we found the service was now rated 'requires improvement' in each of the five questions. This was because we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We also identified a number of areas that, although not breaches of regulations, required improvement to meet with current guidance about good practice for services for people with learning disabilities or autism.

This unannounced inspection took place between 17 January 2018 and 21 February 2018. We visited the service on 17 January 2018 and between 05 and 21 February, we reviewed information sent to us by the registered manager and spoke with the relative of a person who used the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk Assessments were not adequately detailed or individualised. Some risk assessments had not been recorded when decisions had been made to put restrictive practices in place.

Medicines were not managed safely because stock taking processes were not effective and protocols were not in place to ensure 'as required' medicines were administered as intended by the prescriber.

Although the premises were sufficiently clean, effective measures to control and prevent infection had not been taken. The arrangements for managing clean and dirty laundry, the storage of cleaning materials and the auditing of infection control measures required improvement.

People felt safe living at the service, with the staff and with the support the staff gave them. People were

protected as far as possible from abuse and avoidable harm by staff who were trained and competent to recognise and report abuse.

There was a sufficient number of staff to make sure that people's needs were met safely. There was an effective recruitment process in place to reduce the risk of unsuitable staff being employed. Staff were clear about their responsibility to report accidents, incidents and concerns.

Assessments of people's support needs were carried out before the person came to live at the service to ensure that their needs could be met. Mobile phones for use when people went out unescorted were available to people. However, the use of technology had not been explored beyond this and opportunities were lost to determine whether or not people might benefit from this.

Staff received induction, training and support for them to do their job well. However, knowledge of the Mental Capacity Act 2005 was not strong across the staff team and this had an impact on how people were supported to make decisions about their care.

People had enough to eat and drink and menus appeared balanced. However, people told us that food sometimes ran out so menus were not always accurate. People's choice, preferences and involvement in preparing meals were not sufficiently promoted.

When required, staff supported people to access external healthcare professionals such as GPs and the service worked well with other service providers to meet people's needs.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way. They were not sufficiently involved in planning their support or enabled to be as independent as they wanted to be.

People had good relationships with staff and described them as kind and supportive. Staff knew each person well.

Each person had a support plan but these were task centred and not sufficiently personalised. People were not encouraged to identify goals and aspirations or make plans as to how they would achieve them.

A complaints process was in place and people and staff were confident that any issues would be addressed by the management team. Some people had plans in place to support them to have a pain free and dignified death in line with their wishes, and in some instances, the wishes of their family. Other people did not have these out of choice.

Although the manager spoke of wanting to promote a person centred culture within the service, there was a lack of clear strategy about how this was to be achieved, and current practices promoted a task centred and risk averse approach to care. Due to a lack of clearly understood values, staff lacked a coherent approach to their work, which impeded people's opportunity to develop their skills and have control of their own lives.

The quality assurance system in place was not robust and did not identify issues found at this inspection. Audits and monitoring checks on various aspects of the service were carried out but it was not clear how these had been used effectively to make continuous improvements to the service.

People, their relatives, staff and other stakeholders were asked to give their views about the service and how it could be improved.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk Assessments were not detailed and did not always identify risks that were specific to individual people..

People were not protected from the risk of infection and medicines were not managed safely.

People were protected from abuse because staff understood the signs to look for and the process for reporting concerns.

There were enough staff deployed to keep people safe and effective staff recruitment reduced the risk of unsuitable staff being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act were not always met.

People had enough to eat and drink, but the way mealtimes were organised meant their individual preferences, choice and involvement were limited.

Staff received training to provide them with the skills and knowledge to support people who used the service.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not fully involved in planning their care and support, and were not encouraged to be as independent as possible.

People were supported by caring staff who knew each person well.

Staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Support plans and the organisation of care were task led rather than person centred.

People were encouraged and supported to find meaningful activities to be involved in.

Complaints and concerns were responded to well.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was not a person centred culture within the service.

The provider did not have a clearly understood set of values that underpinned the service and therefore staff had little direction.

Systems to monitor the quality of the service were not robust and did not support improvements to the service.

People, relatives, staff and other professionals were encouraged to share their views about the service.

The service worked in partnership with other professionals to meet people's needs.

1 Lansdowne Road

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.

This unannounced inspection took between 17 January and 22 February 2018 and was carried out by one inspector.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our visit we observed how the staff interacted with people who lived at 1 Lansdowne Road. We spoke with five people who lived there, three staff and the registered manager. After the inspection we spoke with a relative of one person who lived at the service. We looked at three people's care records as well as other records relating to the management of the service. These included records relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

Requires Improvement

Is the service safe?

Our findings

There were risk assessments for each person to give guidance to staff about where they were more at risk such as risks associated with specific medical conditions, mobility, swimming, accessing the community, travel and using the kitchen. However, we found that the information within these risk assessments was not always sufficient to direct staff on how to minimise risks whilst promoting people's independence. Some risk assessments were generic, referring to 'the person', rather than using the individual's name, and were identical for each person we looked at. Therefore risks had not always been assessed with the specific individual in mind, taking account of their particular strengths and needs.

From care records, we identified that there were some perceived risks to individuals for which no risk assessment had been put in place. In some instances, action had been taken to reduce the risk, but in the absence of a risk assessment, no rationale for the action was in evidence. For example, a decision was made to disconnect some equipment in one person's private space to avoid the risk of them using it unsafely and causing harm to themselves or others. No risk assessment had been completed in relation to this. There was also no evidence that there had been a process undertaken to make this decision, ensuring this was done either with the person's consent or in their best interest, or that it was the least restrictive way to minimise the risk of harm. The impact of this was that it reduced the person's opportunity to be independent with or without the support of staff.

The registered manager told us that there were rare occasions where certain people who used the service would remain in the building for short periods with no staff present. During these times, the kitchen was locked to prevent the risk of people using it unsafely and hurting themselves or causing a fire. There was no evidence to demonstrate that a process had been followed to assess the risk and identify that this was the least restrictive way of dealing with it.

The arrangements for managing laundry were not sufficient to prevent the risk of infection. The laundry area was small and located next to the kitchen with only one doorway. There was insufficient space to ensure that clean and dirty laundry were kept separate. The manager told us that staff were expected to bypass the kitchen by coming in and out of the laundry through the back door. She acknowledged that this did not always happen in practice and that staff did walk through the kitchen with clean and dirty laundry on occasion. This was not good practice in relation to the prevention and control of infection. The manager informed us that there were plans in place to move the laundry room into a vacant room on the first floor to reduce the risks associated with such a small laundry space located close to the food preparation area. The manager told us that regular infection control audits were completed, but there was no documented evidence to support this.

We noted that a cupboard which was used to store cleaning products was also used to store food. This presented both an infection risk and a risk of people accidently ingesting cleaning products if they were to spill onto the food. The manager confirmed that all food would be removed from this cupboard immediately.

We checked the way medicines were managed and found some areas where improvements were required. Stock of medicine coming in to the service, being carried forward from one month to the next or returned to the pharmacist, was not effectively recorded. This included medicines provided in loose packets as well as those in prepared blister packs. This meant we were not able to check whether the number of tablets held at the service tallied with the number signed as having been given. Where people were prescribed 'as required' (PRN) medicines, there were no protocols in place to advise staff on what the medicine was for and when it was appropriate to administer the medicine. This meant that people may not have received these medicines as intended by the prescribing physician. We discussed this with the registered manager who told us that staff would never administer PRN medicines without checking with the on call manager first. However, a clear protocol for the use of each PRN medicine used by each person would help to ensure consistency of administration. This is particularly important in relation to any medicines that are prescribed for the treatment of agitation or distress.

The issues we identified in relation to risk assessments, infection control and medicines management were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We looked at the medicine administration records (MAR) for three people and found these had been completed accurately with no unexplained gaps. Some people who used the service administered their own medicines and we saw that risk assessments had been completed in relation to this.
Incidents and accidents were recorded but we saw little evidence to support that these records were used to identify trends and patterns to incidents, or to learn from events and make improvements to the service.

People told us they felt safe with the service they received at 1 Lansdowne Road and with their support workers. They gave us a number of reasons to explain why they felt safe, including sufficient numbers of staff being available to assist them, support to take medicines, and to manage money safely. Two people mentioned that technology, such as mobile phones helped them feel safe when out in the community. One person said, "We are safe here. I have friends and staff help me." Another person said, "When I go out, I take my mobile phone so I can speak to them (staff) if I need to."

The provider had an up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have about people's safety. Information about safeguarding was on display throughout the home and it included contact details for the relevant agencies for staff to refer to when needed. Staff had received training in safeguarding people and those we spoke with were able to tell us about signs they would look for that could indicate a person may have experienced abuse. They all said they would report concerns to the registered manager but were less clear about the external agencies that should be informed about any safeguarding concerns.

There were enough staff available to keep people safe and meet their needs in a timely manner. The registered manager told us that additional staff were rostered on duty to make sure that activities, appointments, outings and home visits could take place if people needed staff support. The provider had a robust recruitment process in place. This included carrying out pre-employment checks such as references and a criminal records check, which had to be satisfactory before the new member of staff was allowed to start work. This helped to ensure that only staff suitable to work at this service were employed.

On the day of the inspection, the service was clean. The majority of the cleaning was done by support staff, although the manager told us that attempts had been made to encourage people who used the service to become more involved with cleaning.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of this inspection, the registered manager confirmed that no one living at the service either had or needed a DoLS authorisation in place. However, we noted that some restrictions were in place that may have meant a DoLS authorisation could have been warranted in order to validate the decision to place restrictions on the person's freedom.

We checked whether the service was working within the principles of the MCA. We found that understanding of the MCA was not strong across all levels of the staff group and this impacted on the way in which decisions were made in the service. We saw from records that capacity assessments had been completed appropriately when it was felt that people may lack the capacity to make certain decisions. However, we found that some decisions were being made about people's care without either gaining their informed consent (If they had capacity) or assessing their capacity, making and recording decisions in their best interests, as required by the legislation. For example, we saw an entry in the minutes of a recent staff meeting which stated, "It was raised that residents like to go to the shops on a Saturday and a Sunday to buy magazines and sweets. However, one day is enough, the other day they can go for a walk to the park or the river. They do not need to spend money." This appeared to be a decision that had been made on behalf of the people who used the service as a group rather than individuals, with no assessment of their capacity to manage their own finances or make decisions for themselves about how they wished to be supported to do so.

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

Although people had enough to eat and drink, the way in which meals were planned, bought and provided did not maximise people's individual choices, preferences or involvement. There was a three week rolling menu planned that had been reviewed by a dietitian and was considered nutritionally balanced and suitably varied. Many of the planned meals were homemade and recipes were provided to support staff to cook the meals as intended. On the day of the inspection, we saw people had a freshly cooked meal of lasagne and salad which was of a good standard and looked appetising. People told us the meal was very nice. There was little evidence that people who used the service were meaningfully involved in preparing meals.

The manager told us that people had been involved in the development of the menu which was changed

seasonally. However, this menu was set and there was little evidence to indicate that individual preferences were considered on a day to day basis, rather than just in the planning of a menu that broadly covered preferences of the group of people living at the service. The service ordered groceries on line for delivery once a week based on the planned menu. This had an impact on the way in which choices were accommodated with regard to meals. We saw a message from the manager to staff instructing them not to change the menus as it would lead to food being wasted, and one person told us that food items sometimes ran out. They confirmed that this sometimes meant the menu was not an accurate reflection of the meal eaten by people on that day. This was also acknowledged by staff. This meant that, although menus indicated that people's nutritional needs were met, we could not be sure this was always the case. People's individual choices and preferences were compromised because bulk shopping did not allow for people to eat independently from the group. The manager told us that people were able to have some variation from the set menu, in the form of jacket potatoes or frozen meals. However, this was not sufficient to illustrate that people's individual preferences were at the centre of this aspect of the service.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that, beyond the use of mobile phones, little consideration had been given to how technology might support people's needs to be met effectively. Some people were physically checked on by staff at various times of the day and night, which they were known to find intrusive. The service had not considered how people's safety could be supported by technology, which might reduce the need for the invasion of their privacy. People did not have access to the internet other than in the staff areas. This reduced their access to resources that may have been of interest to them as well as information that could support their independence.

People were supported to access additional health and social care services, such as GPs, dietitians, chiropodist and dentists so that their health needs were appropriately met. Staff told us they had positive relationships with the various healthcare professionals that visited the service and were confident to make referrals as necessary. Records also indicated that staff responded quickly to people's health needs and they sought advice from other health and social care professionals when the need arose. Advice from other healthcare professionals relating to the care and support being provided by the service was incorporated into the individual person's care plan.

From the care and support records we looked at, we saw that people's needs and preferences were assessed prior to them coming to live at the service. The assessments identified people's needs in relation to issues such as eating and drinking, mobility, communication, personal care, and any specific health conditions. From this process, a care plan was developed to identify each individual need and what support was required from staff. Care plans we looked at contained basic information about people's needs, but lacked detail about the person's preferences for how they wished to be supported. We saw that care plans were regularly reviewed and updated when people's needs changed. Staff told us that they kept up to date with changes in people's needs by talking to them, reading the care plans and through daily hand over meetings when coming on shift.

New staff underwent an induction process, which included training and shadowing experienced staff. Further training was then offered regularly to ensure staff were confident and competent to carry out their role. Topics included health and safety; moving and handling; food safety; first aid; and safeguarding people from abuse.

Staff said that most of the training was computer-based and they undertook a test at the end of each

training session to make sure they had understood and learnt from it. The registered manager also checked what staff had learnt, during observation, supervision and in staff meetings. Records showed that most training considered mandatory by the provider was up to date, although some refresher training was outstanding. The manager told us that they regularly chased staff to complete this training and would address this with them again at the earliest opportunity.

Staff were satisfied with their training and said it helped them to do their job more effectively. About one training course they had recently attended a staff member said, "It really made me think differently about my job. It made me more aware of people being individuals." Additional training was available to staff who wanted to develop their knowledge and skills further.

Staff felt supported by their colleagues and by the registered manager. They had one-to-one supervision sessions which took place approximately four times a year, although the manager told us they were planning to increase the frequency of these to bolster the day to day support offered to staff. At the time of the inspection the manager had put a plan in place to carry out staff performance reviews (appraisals), but had not implemented this yet.

We looked at whether people's needs were being met by the adaptation, design and decoration of the premises. People living at the home said they found it comfortable and communal areas were pleasant, although the décor was tired in some places, and a recent kitchen refurbishment had not been completed to a good standard. The manager told us this had been raised and was to be addressed by the supplier. People's bedrooms were personalised to their own taste. We saw that, although people had communal and individual areas within the building, as well as a garden, there was no other space for people to meet up in private with visitors other than their bedrooms.

Requires Improvement

Is the service caring?

Our findings

There was little evidence to demonstrate how people were actively involved in planning their care and support. Each person had a keyworker who had responsibility for taking a particular interest in that person's care and support. Although people we spoke with were positive about their keyworkers, there was a lack of evidence that these relationships supported people to be more involved in their own care, setting goals and working towards achieving them.

People were not supported to be as independent as they could be. The manager told us that the aim of the service was to promote people's independence with a view to them developing the skills to move on and live independently in the future. We asked the manager how many people had successfully moved on to live elsewhere more independently, and they confirmed that no one had done this to date. Many opportunities to involve people in everyday activities, such as cleaning, cooking, and shopping were missed and all of these tasks appeared to be routinely completed by staff.

The manager told us that she was continuously challenging staff practice in relation to this, reminding them that their role was to assist and enable rather than to do tasks for people. However, there was a lack of guidance on how staff were to do this in a way which took account of people's individual strengths, needs and preferences. In addition, the way in which the service was organised contributed to this, with many aspects of the service catering for the combined general needs of the group, rather than the needs and preferences of each individual person. We asked the manager why the shopping was done in one large weekly online order rather than people going to the local supermarket. They told us that it was because there was such a lot of shopping due to the number of people living at the service. By organising meals and shopping in this way, people were not getting the opportunity to develop the skills necessary to become more independent in this area. This meant that, although the manager stated that she wanted to challenge task centred practice, the way in which the service was run was in conflict with this, and perpetuated existing practice.

Staff told us that the support provided to people varied depending on who was on duty, with some staff favouring a traditional care role and others, more of an enabling model of support. This lack of consistency was exacerbated by a lack of clear guidance to staff, and may have led to people feeling confused about what support to expect depending on which staff was providing assistance. This meant the level of support people received was dependent more on staff preference than on their own independence skills, strengths and needs.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staff were aware of the importance of maintaining people's privacy and dignity when assisting them with personal care and spoke of measures such as keeping people as covered as possible, and closing doors and curtains. People told us that staff usually knocked on their bedroom doors before entering, although one person said, "Sometimes I think they forget."

People we spoke with made positive comments about the staff. One person told us, "I like it here, I have my friends and I can talk to staff. They are good." Another person said, "Staff help me and talk to me nicely." During the inspection we saw people appeared comfortable in the company of staff and that positive relationships had developed between them. Staff demonstrated a caring attitude and appeared to know each person well. We saw staff held meaningful conversations with people and that there was plenty of laughter and banter enjoyed by all.

Staff supported people to maintain contact with their friends and family. People told us staff supported them on home visits to enable them to get to their family home and back. Family members and friends were welcome to visit. Advocacy services were available if someone wanted an independent person to support them to share their views. At the time of the inspection, one person made use of an advocate.

Requires Improvement

Is the service responsive?

Our findings

People and their families, where appropriate, had been involved in ensuring accurate information about people's needs and preferences was available to staff. For each person, a support plan was developed which was intended to identify how the service should support them in the right way to meet their needs, in the way they preferred. However, we found that the support plans we reviewed lacked detail and were task based rather than person centred. Although the plans covered people's needs in relation to various activities of life, such as eating, sleeping, communication and personal care, we found there was a lack of information about how needs were to be met in line with the person's preferences. The support plans directed staff about what to do, but gave little information about how to do it for each particular person to ensure they received the best support suited to them.

Information under some sections of the support plans was disorganised. For example, one person's communication support plan did contain some information about their preferences, but in relation to shaving. It also covered their support needs in relation to crossing the road. This meant the information could get overlooked because staff would not be likely to look for it in the 'communication' section, but rather the personal care and community support section. Therefore people might not receive the most appropriate care to meet their needs.

There was no evidence that people were supported to have goals or aspirations, and no evidence of how staff were working to support people to learn new skills or become more independent. Support plans were mostly in written format and no consideration was given to providing this information in a more accessible way for those people who were not able to read. In the support plans we looked at we saw that some sections had been previously developed in accessible format, but this had not been continued in more recent updates. Of the people we spoke with, none were aware of their support plans or what information was held within them.

The registered manager told us that she was working to raise the staff group's awareness of person centred care and had plans to introduce a 'resident of the day' system to promote this. She explained that 'resident of the day' meant each person who lived at the service would have one day a month specifically allocated to them. On this day they would, "Have their records checked, do their room, and choose the activity and the meal for the day." It is good practice for a service to have systems in place to ensure that each person's care records are kept up to date and in good order. However, in a person centred service, the other aspects of 'resident of the day' would be a given and would take place every day. Many aspects of the service at 1 Lansdowne Road were organised around the needs of people living there as a group. For example, group shopping done online, group menus and group mealtimes. In addition, decisions made by staff about restrictions such as locking the kitchen, disconnecting equipment, and how people spent their money did not fully take into consideration the individual strengths and needs of the people they supported. Therefore, the way in which the service was organised did not support people's individual needs to be sufficiently prioritised.

This demonstrated that the home was not currently working in line with the values that underpin the

'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion; enabling people with learning disabilities and autism to live as ordinary a life as any citizen.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take part in activities and maintain their interests. We saw that people were supported to attend social clubs in the evenings, as well as take part in activities such as swimming, going out in the local community to cafes, cinemas, parks, and going on holiday. People who had religious beliefs were supported to attend their place of worship and to maintain their faith. Most people attended various day services in the local area, and some people worked either voluntarily or in a paid capacity, for one or more days per week.

The provider had a system in place so that people and their relatives knew how to raise a complaint if they needed to. A complaints form in an accessible format was available and staff said they would assist a person to complete the form if they wanted support. The form would then go to the registered manager and staff were confident any issues would be addressed. People told us they liked the service and did not have any complaints. One person said, "I can talk to [registered manager] or [staff name]. I would tell them. There's no need to be worried. They will talk to me." We saw that people had raised complaints in the last year in relation to a shared vehicle provided by the service. Although the result of making this complaint was not that the vehicle was changed, we saw the manager had responded appropriately to the concerns raised, and people we spoke with confirmed that the matter had been resolved satisfactorily.

We saw that some people's support plans contained information about their wishes at the end of their life to enable them to have a dignified and pain free death. We also saw that information about what happened at the end of your life and what you could do to make plans was available to people in an accessible format. Some people had chosen not to complete this element of their support plan. The manager told us this choice was respected and that the issue of end of life planning would always be offered to them if they changed their mind at some point in the future.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was not employed at the service during the last inspection in August 2015.

The culture within the service was not sufficiently person centred, and although the manager told us that she was aware of this and working towards changing it, we found there was no coherent strategy in place to support her to do this. Many of the systems in place at the service supported a task centred and generic approach to care. We also saw several examples of messages to staff from the manager which reinforced this model of support. The content of many records associated with care also promoted a more controlling model of care, as did a risk averse culture which placed restrictions on people without going through appropriate processes to validate this action.

We found there was not a clearly defined set of values that were understood by all staff, and this led to staff working to whatever style they personally favoured. This had an impact on how independent people were able to be because this depended on which member of staff was on duty.

Although there were systems in place to monitor the quality of the service, these were not robust and did not pick up the issues identified at this inspection. The manager carried out a monthly audit covering various aspects of the service, such as medicines, accident and incident forms, safeguarding events, vehicle checks, fire records, health and safety. Although the manager told us she carried out infection control audits, there was no evidence to support this. Although audits identified action that was to be taken, there was no information to indicate whether or not this action had been completed. After the inspection, the manager sent us a copy of the most recent monitoring visit carried out by the provider. This was quantitative in nature and did not go into detail about what action was needed to improve the quality of the service people received. This did not enable registered manager to have a clear direction or to know how to continuously improve the service.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

There was a lack of awareness of current guidance in relation to good practice in services for people with learning disabilities. The recent paper "Registering the Right support" is clear that the values that underpin a good service are choice, independence and inclusion; that people with learning disabilities and autism have the same rights to an ordinary life as all citizens. The service demonstrated that they did not currently put these values at the heart of the service they provided. Also within this guidance it is stated that new services for people with learning disabilities, with few exceptions, should support only small number of people. Existing services should consider the size of the service when forward planning and when considering new placements as vacancies arise. At the last inspection in August 2015, 11 people were living at 1 Lansdowne Road. By this inspection the number of people living at the service had increased to 13. We discussed this with the manager, who was not able to provide any evidence to demonstrate that the principles of 'Registering the Right Support' had been considered when increasing the numbers of people living at the

service.

People told us they liked the registered manager and that she was approachable. One person said, "Yes she listens to me if I tell her things." Another person said, "She will sort it out if I'm not happy." Staff we spoke with said they felt they received good support from the manager and that she was approachable. One member of staff said, "She has been brilliant." All the staff we spoke with confirmed that they would feel comfortable to raise concerns with the manager and they were confident she would take appropriate action. One member of staff confirmed they had experience of bringing concerns to the manager, who had been supportive, taken action and maintained their confidentiality.

There were regular staff meetings and residents meetings to support people and staff to express their views. A survey was carried out annually to encourage people, their relatives and other professionals involved in the service to share their views and make suggestions about how the service could be improved. The survey for this year had not taken place at the time of the inspection, but a previous survey showed positive results, and we saw that comments made had been used to make improvements to the service.

The registered manager told us, and records confirmed, that the home worked in partnership with other key agencies and organisations such as the local authority, hospitals and other health professionals to ensure there was provision of joined-up care. Where required, staff also shared information with relevant people and agencies for the benefit of the people living there.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not supported to have autonomy or to be as independent as possible

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Decisions about people's care were not always made in line with the principles of the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always in place or were not sufficiently detailed. People were not protected from the risk of infection and medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems were not effective.

A person centred culture was not effectively promoted in the service.