Freeways

Underhay House

Inspection report

639-641 Muller Road
Eastville
Bristol
BS5 6XS

Tel: 01179519094
Website: www.freeways.org.uk

Date of inspection visit:
28 November 2017
30 November 2017

Date of publication:
11 January 2018

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

This inspection was carried out on the 28 and 30 November 2017. Underhay House provides accommodation and personal care for 12 people. There were ten people living in the home at the time of the inspection. People who live at the home have a learning disability. This was an unannounced inspection, which meant the staff and provider did not know we would be visiting.

There have been three changes in management in the last twelve months. A new manager had been appointed and had started the day before the inspection. They had worked in a number of Freeways services as an assistant manager and then as a trainee manager since August 2016. They had submitted an application to us to register. 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.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The changes of management have had an impact on the way the service was operating. This was because one of the managers had not completed what was expected of them in respect of completing staff supervisions, monitoring staff training and completing care reviews. This had been addressed by the provider who have been able to show us evidence that they had been addressing these concerns with this manager. The manager appointed in May 2017 had devised an action plan that was being monitored by the senior management team of Freeways. The newly appointed manager was committed to implementing the action plan to address these shortfalls to ensure on-going compliance.

Some improvements were required to the environment to ensure it was safe and meeting the needs of people. Some areas of the home were not clean and carpets and furniture were stained.

People had access to healthcare professionals when they became unwell or required specialist equipment. Feedback from health and social care professionals was generally positive in respect of the staff's approach to people and the delivery of care.

People were protected from the risk of abuse because there were clear procedures in place to recognise and respond to abuse and staff had been trained in how to follow the procedures. Systems were in place to ensure people were safe including risk management, checks on the equipment, fire systems and safe recruitment processes. However, not all staff were following the guidelines set down by professionals, which meant a person might be of risk of choking.

There was not always sufficient numbers of staff supporting the people living at the service. Regular meetings were taken place however, other systems to support staff such as one to one meetings were not happening at regular intervals and, there were no annual appraisals of staff's performance. Training had lapsed throughout the year for staff due to the management changes. Training focused on mandatory training rather than the health and social care needs of people, which meant there was a risk of people not receiving effective and consistent care that was based on current best practice.

People had a care plan that described how they wanted to be supported in an individualised way. These had not been kept under regular review. The provider was aware of these inconsistencies and showed us evidence of how they were addressing the concerns about compliance. There was an action plan in place to address this and work had commenced on this area since June 2017 but this was still work in progress.

People were treated in a dignified, caring manner, which demonstrated that their rights were protected. Where people lacked the capacity to make choices and decisions, staff ensured people's rights were protected by involving relatives or other professionals in the decision making process. The provider had submitted applications to the appropriate authorities to ensure people were not deprived of their liberty without authorisation.

The service was not always well led; although the provider completed regular monitoring checks these were not considered to be robust. We have recommended the provider seek advice and guidance from a reputable source, about how from a provider prospective they can monitor the quality of the service involving people, their representative and other stakeholders.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Improvements were required to ensure people received a safe service. This was because there was not always sufficient staff to support people. Some areas of the home were not cleaned to a suitable standard.

Risk assessments were in place to keep people safe but they were not always followed.

Staff had received training in safeguarding so they would recognise abuse and know what to do if they had any concerns.

Recruitment procedures were in place to ensure people were supported by staff that had the right skills and were suitable to work with vulnerable adults.

Medicines were well managed with people receiving their medicines as prescribed. Not all staff had been re-checked in respect of their competence in this area.

Is the service effective?

Requires Improvement

Some improvements were required to ensure the service was effective. This included ensuring staff receiving suitable training that reflected the needs of the people they were supporting. There was a lack of consistent support mechanisms for staff including meeting with their line manager on a regular basis and an annual appraisal.

Areas of the home would benefit from a refurbishment programme.

Staff were knowledgeable about the legislation to protect people in relation to making decisions and safeguards in respect of deprivation of liberty.

Other health and social care professionals were involved in the care of people and their advice was acted upon. People's health care needs were being met.

People had access to a healthy and varied diet, which provided them with choice.

Is the service caring?

Good

The service was caring.

People were cared for with respect and dignity. Staff were knowledgeable about the individual needs of people and responded appropriately. Staff were polite and friendly in their approach. There was a good level of involvement.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care plans had not always been kept under review to reflect their changing needs. There was an action plan in place, which the new manager was implementing to address these shortfalls.

People were supported to take part in regular activities both in the home and the community.

People could be confident that if they had any concerns these would be responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been three changes of manager in twelve months, which has had an impact on the leadership within the service and direction given to staff. Improvements had been slow to implement due to these changes.

The quality of the service was reviewed by the provider/registered manager and staff. However, the checks that been completed had not identified shortfalls in the management of the service. Moving forward it was evident; the previous manager had been proactive in implementing an improvement plan during their short employment at Underhay and this was being followed by the newly appointed manager.

Care Quality Commission

Underhay House

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 November 2017 and was unannounced. One inspector carried out the inspection. The previous inspection was completed in July 2015 when the overall rating for the service was good. However, at that inspection the service was rated as requires improvement in our key question area of; is it safe. This was due to the significant needs of a person who has since left the home.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. Before the inspection, we contacted six health and social care professionals and received feedback from four of them. Their comments are included in the main body of our report.

We spoke with four people who used the service and spent time with other people. This was because some people were unable to tell us about their experience of living at Underhay House. We spoke with the new manager, a senior manager, the chief executive of Freeways, the assistant manager, and three members of staff.

We looked at the care records for two people who used the service and other associated documentation. We also looked at records relating to the running of the service. This included staffing rotas, policies and procedures, quality checks that had been completed, supervision and training information for all staff.

After the inspection, we contacted a relative for their views on how the service was delivered.

Requires Improvement

Is the service safe?

Our findings

Some people told us they felt safe and others we observed were comfortable with the staff that supported them. People actively sought out the staff to tell them about the activities they had completed. When people became upset they actively sought out staff support to either talk with them or have a hug. This showed people were relaxed in the company of the staff. A relative told us, "My son is in safe hands and I have no worries".

Staff told us there was not always sufficient staff to keep people safe, or support them with their daily living and social activities. They told us sometimes there was not enough time in the day to complete all the household chores and documentation especially when there was only one member of staff supporting ten people.

The new manager told us there should always be a minimum of two staff on duty to support people throughout the day and evening. In addition there is an element of 1:1 support provided as well as some funded 1:1 hours, which an additional staff member is required to complete. There is also one member of staff providing waking night cover.

We reviewed the rota for October and November 2017 and found there were four occasions where there was only one member of staff working to support the ten people. We were told this was because staff had phoned in to report their absence at short notice and the bank staff and the preferred staffing agency were unable to cover. This put people at risk of not having their care and support needs met. We saw from three people's risk assessments that when they were in the home together a staff member must always be in close proximity. This would not have been possible if there was only one member of staff on duty, because there would be times when they were involved in personal care with people or completing household chores such as cooking and cleaning. Staff also told us that when they had been short staffed staff had completed a sleep in shift rather than a waking night. Staff told us some people access the kitchen at night to prepare food if they were hungry. One of these people was at risk of choking. This meant there was not suitable staffing levels to ensure people's safety. After the inspection we were informed the night wake in was brought in by Freeways due to the changing needs of service users where it had previously been two sleep in staff.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The manager told us, they were aware of some shortfalls in staffing but with the recent employment of two new staff, this would be addressed. Three staff had left the employment of Underhay House since September 2017. Regular bank and agency staff had been used to cover the shortfalls in staffing during this period.

Some areas of the home were not cleaned to a suitable standard. The carpet in the lounge and soft furnishings were worn stained and dirty in places. The covers over the sofas in the lounge area were also a trip hazard. Staff told us that the seating in the lounge area was low and not suitable for some people who may struggle with mobility. There was also a film of dust over skirting boards and other surfaces in the hallway and two vacant bedrooms. Care staff were expected to undertake cleaning duties alongside their caring responsibilities.

A person in the home raised a complaint to us during the inspection about the cleanliness of the home. They told us some staff did not always complete cleaning to a suitable standard or even left it to other staff to complete. They showed us areas where they were concerned such as picture frames, the television and the furniture outside their bedroom door. They told us in the past they had raised concerns about the cleanliness of the toilets. We saw in one person's bedroom there were sweet wrappers on the floor and the flooring would have benefited from a clean. We checked the cleaning rota, staff had written on the cleaning schedule 'not completed will do tomorrow'. Staff told us people were supported to clean their bedrooms on a weekly basis. Key workers assisted people in keeping their bedrooms tidy.

This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Care records included risk assessments about keeping people safe whilst encouraging them to be independent. Some people were able to access the community independently, be involved in cooking their meals and were responsible for their own money and medicines. It was evident people were empowered to take control over their own lives where they were able. People's mental capacity had been taken into account when such choices had been made and their right to take informed risks had been respected.

Staff were not always following the guidance as detailed by health professionals. This involved ensuring one person was safe when eating their meals. The guidance stated that a member of staff should be present when the person was eating. This was to minimise the risk of choking when eating their meals. We observed that this person was left on three occasions when eating. Staff said that this was because they were eating low risk foods. The guidance stated a member of staff should remain with this person whilst eating at all times, ensuring they ate at a suitable pace and they were encouraged to take smaller bit size mouthfuls. This person was observed coughing whilst eating their meal. This meant this person was at an increased risk of choking.

Another person had a risk assessment about keeping safe in the event they did not return to the home at a pre-arranged time. Whilst it provided staff with guidance before the event which talked about stranger danger, keeping in contact by telephone and the person to let the staff know the approximate time of return. There was no information about what staff should do in the event the person did not return within a certain timescale, who to contact and whether to instigate the missing person's policy.

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staff were confident that the new manager would respond to any concerns raised about poor practice. A safeguarding adult's policy was available for staff to guide them on the procedure to follow. There was a whistle blowing policy, which enabled staff to raise concerns about poor practice. Staff told us safeguarding training was updated annually. Where safeguarding alerts had been raised, the provider had taken appropriate action to minimise the risks to people. This was to ensure risk assessments were in place to ensure staff were present when three particular people were in the home. These strategies had reduced the incidents between these three people. However, staff told us this was not always possible when there was only one member of staff working in the home. The last incident involving these people was at the end of

September 2017 and the appropriate agencies had been informed.

Each person had a file containing their medicine administration records, an up to date photograph, preferences on how they liked to take their medicines and information in respect of medicines they were prescribed. Information was available to staff on 'as and when' medicines such as pain relief. This included what staff should monitor in respect of when and how these medicines were to be given. Where people looked after their own medicines risk and capacity assessments had been completed to ensure they were confident in this area. One person told us they looked after their own medicines and required no staff support in this area. People had lockable storage in their bedrooms to keep their medicines safe. Staff supported people to go to their bedrooms when they needed support with their medicines. This meant they were involved in the process.

Staff had been trained in the safe handling, storage, administration and disposal of medicines. All staff who gave medicines to people had received training. Two new staff were planning to complete this during the week of the inspection. A member of staff told us they could not always get a second witness signature to check medicines had been given by another member of staff. This was because they were either bank or agency staff and their competency had not been assessed. We reviewed staff medicine competency checks and could see that these had not been reviewed annually. These were due in July and August 2017 for some staff. They assured us this would be completed.

Environmental risk assessments had been completed, so any hazards were identified and the risk to people removed or reduced. Checks on the fire and electrical equipment were routinely completed. Maintenance was carried out promptly when required. Staff had participated in regular fire drills and fire training. Individual fire risk assessments were in place to guide staff on the support each person required in the event of a fire. These are called personalised emergency evacuation plans. The new manager told us some of these required a review along with the home's fire risk assessment for the service as this had not been reviewed in the last twelve months by the previous two registered managers.

The manager clearly understood her responsibilities to ensure suitable staff were employed in the home. This included seeking a minimum of two references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. The manager told us new staff would not commence working with people until all the satisfactory checks had been completed.

Recruitment information was held at the main office of Freeways. The operations manager and manager told us Freeways had recently reviewed how they retained this information and this was now kept in the Human Resources Department. They said there was meant to be an overview record of the information held at the main office but this had not been completed for Underhay House. The manager told us a member of staff from Freeways HR department would be visiting to complete this with them. We will be arranging with the provider to review the recruitment information held at the head office.

Requires Improvement

Is the service effective?

Our findings

The manager told us all staff had recently had a supervision with the previous registered manager. However, throughout the year staff had not received supervisions at the frequency expected by the provider. The previous registered manager had completed a supervision with all staff. However, prior to this they had not been completed since December 2016. All staff should have received a supervision at least six times per year in accordance with Freeways supervision policy. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The staff told us their supervisions had fallen behind whilst they were short staffed and because there had been changes in management.

Staff told us they had not had an annual appraisal of their performance since working in the home. Some staff had worked in Underhay House for more than two years. The manager said they had not been able to find any annual appraisals for the staff employed at Underhay House. This meant the support mechanisms for staff were not in place to ensure they had the skills and knowledge and support to fulfil their roles.

There had been gaps in training for staff completing their mandatory training such as fire, first aid, food hygiene, moving and handling and health and safety. The previous manager had devised a comprehensive action plan in relation to ensuring staff had received their mandatory training, which was being monitored by the operations manager.

When we reviewed the training records, there was very little training completed on the specific health and social care needs of people living at Underhay House, such as supporting people who may use sign language, supporting people with epilepsy, diabetes or dementia. Some staff told us they had been new to care. The new manager recognised that due to the change of management staff may not have completed all the training that was required of them to support people effectively and in a person centred way. They told us as a priority they were planning training on diabetes and were liaising with the community learning disability team. This training had been an area that the previous registered manager had identified in the provider information return (PIR) as an area to improve. They had completed this in June 2017 and this training had not been arranged five months later.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Since the last inspection, some areas of the home had been redecorated including the corridors, communal areas and five bedrooms. This included new flooring. These areas looked bright and fresh. A new fence and gate had been erected to the front of the property making this area safe and secure. The manager told us the decoration of these areas had taken place three weeks before the inspection. A health and social care professional told us this had been a vast improvement, as some areas of the home had looked tired and unkempt.

We saw that some areas of the home still required improvement such as the worn sofas in the lounge area and some bedroom furniture, which was old and not fit for purpose. This had included mattresses. The manager told us new mattresses had been ordered for five people. We saw pillows that were stained in a bedroom a new person was planning to move into in January 2018. Two people's bedroom curtains were not fit for purpose were too small for the window and had come away from the curtain rail. This not only looked unsightly but also compromised people's privacy. The bathroom on the ground floor had black spots of mould on the wall and brown staining on the floor by the bath panel in the first floor bathroom. An infection control audit had been completed in August 2017 where it was noted that the worktops in the kitchen needed replacement because it was chipped and the wood had been exposed underneath the laminate. These areas still required addressing.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

The chief executive visited Underhay House during the inspection and confirmed they were aware there was some outstanding works needed in relation to the refurbishment of Underhay House. They told us they had already agreed a budget for the new sofas but due to the change of management, these had not been purchased.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist, chiropodist and an optician and attended appointments when required. These records included the reason for the appointment, the discussion with the GP and treatment plan and any follow up required such as results from blood tests. These were very comprehensive. Key workers completed a monthly review of all health care appointments attended. Feedback from the GP practice was positive with staff seeking advice when required and being knowledgeable about the people they were supporting.

People had a health action plan, which described the support they needed to stay healthy. Where people's needs had changed, referrals had been made to other health care professionals. This included the community learning disability team, which is made up of nurses, physiotherapists, dieticians, occupational therapist and consultant psychiatrists.

Staff were concerned about the health care needs and treatment plan for one person. This was because they had been incorrectly diagnosed, which had delayed the treatment they required. Staff were now liaising with a specialist nurse in providing treatment. The specialist nurse was assessing the person's mental capacity as they had refused to follow the treatment plan. It was evident the staff were working with professionals in ensuring the person was receiving treatment that was in their best interest. Records clearly recorded where the person had refused treatment and what support staff had offered including seeking advice from the person's GP.

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's care plans clearly described how the staff supported people to make day to day decisions, for example about what to wear, to eat and drink and how they wanted to spend their time. Staff were aware of those decisions that people could and could not make for themselves.

Meetings were held so that decisions could be made, which were in people's best interests involving the person's relative, advocate and other health and social care professionals. Records were maintained of these discussions, who was involved and the outcome.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The newly appointed manager was aware of who had a DoLS authorisation in place and when this required resubmission or where an application had been submitted, and any special conditions that were in place such as; making a referral to a health professional, keeping in contact with family and additional one to one hours. Staff confirmed that one person had been allocated one to one hours for a period of three months. They told us this time was used to motivate the person in the mornings and provide opportunities to go out. Records were maintained of the one to one time. A health care professional told us they had been concerned about how this was being utilised but saw there had been improvements when the last registered manager took up post. They felt this was because there had been a high turnover of staff and management changes, which had impacted on the consistent care the person was receiving. They told us there were now strategies for staff to follow to help with motivation and this had helped, as staff were more consistent in their approach.

People told us they enjoyed the food that was made available to them. There was a free choice at lunchtime, which was relaxed with people coming to the dining area at different times throughout the lunchtime period at a time to suit them. Staff were available to support them if needed with food preparation and choices available. People made a selection of sandwiches, snacks on toast and healthier options such as salad. The main meal was cooked in the evening. People took it in turns to choose and cook an evening meal. Staff said some people were more motivated than others to help with cooking. The manager told us staff ordered the shopping on line and this was delivered twice a week to ensure there was sufficient food available. They told us they were planning to review the practice of on line shopping, to offer people the opportunity of being supported to go out shopping to purchase the ingredients they needed. This would enable people to have more control and choice in this area. People were weighed monthly and any concerns in relation to weight loss were discussed with the GP and other health professionals.

Underhay House is close to local amenities including public transport. Each person had their own bedroom, which they could personalise as they wish. There was a large conservatory with a quiet area for sitting and a large communal lounge. There was a garden to the rear with accessible access through the conservatory.

Good

Is the service caring?

Our findings

The atmosphere in the home was warm and friendly. It was evident people got on well with the staff that worked in the home.

A health care professional told us, "Carers are friendly, patient and warm in their interactions with the residents and staff in our practice. They genuinely seem to enjoy their work and there is obvious trust in them from the residents". Another visiting professional told us, "Staff have a very caring approach towards people".

The relationships between people and the staff were friendly and informal. People looked comfortable in the presence of staff and chose to be in their company. Staff sought to understand what was wanted and how they could help people. For example, when one person was upset staff took the time to find out what the matter was, and offered them reassurance and a solution, which was to make contact with their family. Another person told staff they were bored, some suggestions were offered and the person was later seen using the home's computer. They told us they were able to go out whenever they wanted and liked to go out for a cup of coffee or the library without staff support.

Staff were observed using a number of different methods to assist people to communicate. This included Makaton a sign language for people with learning disabilities. One person also wrote down what they wanted to say and used this to communicate with the staff and us. One member of staff had completed a sign along course in the use of Makaton. However, other staff had not had this training. They said they had picked this up as they went along, as many of the signs were unique to the person. There were two people who used Makaton to aid communication. There was information in people's care records on how they communicated. The provider told us after the inspection the Makaton training had been cancelled by the local authority on more than one occasion, hence not all staff had received the relevant training.

Each person had an identified key worker, a named member of staff. They were responsible for ensuring information in the person's care plan was current and up to date this included spending time with them individually. Staff were knowledgeable about the people they supported. This included knowing what the person liked, disliked, their personal histories and interests. Staff told us time was allocated to each person to enable them to spend one to one key worker time to assist in cleaning their bedrooms, doing an activity of the person's choice and ensuring they had toiletries and other items such as clothing.

Staff were aware of people's routines and how they liked to be supported. People were supported in a dignified and respectful manner. People were asked how they wanted to be supported, where they would like to sit and what activities they would like to participate in. Staff were aware of who liked to remain in bed and who liked to get up early and this was respected. There were strategies for one person to encourage them to get up and be more involved and motivated. Allocated one to one time had been in place to support this person to go out to places of their choosing. The manager told us they were hoping this funding from the local authority would continue. This was because this was beneficial to the person, as staff could then spend the time they needed to be supported in the morning to get motivated and enable them to go out in the community regularly.

Everyone had their own bedroom, which they could access whenever they wanted. Some people had a key to their bedroom and the front door. Affording them privacy and ownership of their home. One person had a doorbell fitted outside their bedroom door. This triggered a light to enable staff to let the person know they were knocking on person's bedroom door. This was because they were hearing impaired. In addition, they had a sensor under their pillow that was triggered in the event of the fire alarm sounding. People were observed moving freely around their home. There were no restrictions imposed on people and it was seen as being very much their home. Some people chose to spend time in the dining area or the kitchen chatting with staff. People were seen making snacks and drinks in the kitchen area independently.

Staff were seen to knock and wait for the person's response before entering. It was evident staff would not enter a person's bedroom unless they were invited to enter. A person told us they had been concerned once when they were having a private conversation with a social care professional when they felt a member of staff was outside their bedroom door listening. They told us they had raised this as a complaint and it had not happened again. This showed people were listened too.

People were encouraged to be as independent as they were able. Some people were able to go out in the community without staff, some people prepared their lunch and made hot drinks. Care plans included information about people's skills and independence and the support they needed. This ensured staff supported the people consistently encouraging them to be as independent as much as they were able. Staff told us that throughout the management changes there had been a commitment to provide person centred care where people were the focus.

People told us they could have visitors to the home. Care records contained the information staff needed about people's significant relationships including maintaining contact with family. Staff told us about the arrangements made for people to keep in touch with their relatives. This included supporting people to keep in contact by phone or support with transport. A relative told us the staff had been instrumental in supporting their relative to use the bus supporting them initially with the bus route, which they can now do independently.

Social events were organised so that people could invite their friends and family to their home. People told us about two parties they had planned for Christmas Eve and New Year's Eve. They were inviting their friends, family, and people from other Freeway services. People had devised posters to advertise the parties. The newly appointed manager told us they were arranging for one person to visit their family in Wales. Another person told us they regularly visited their family and did this journey on their own.

Requires Improvement

Is the service responsive?

Our findings

Staff were responding to people's needs during the inspection. It was evident that people and the staff knew each other well. People sought out the staff on their return from activities to tell them what they had been doing. The dining and kitchen was evidently the hub of the home with people congregating in this area to chat with staff and other people they lived with.

Some people were sat at the dining table reading magazines or writing. There was also a lounge area where two people were sitting quietly watching television. Both people told us they were not feeling very well and had a cold. Staff were observed checking and making sure they had sufficient fluids to drink and were comfortable. They told us they were happy with how the staff were supporting them. They told us the staff were kind and helped them when needed. We observed a person carrying their plate to the kitchen after lunch. A member of staff promptly said, "Do not worry about clearing the table. Why don't you go and sit down as you are not well". This showed staff were responsive and caring when people's needs changed.

People's needs were assessed before they moved to the home. This included gathering information from the person, their relatives and other professionals involved in their care. The newly appointed manager told us a person had been assessed and was planning to move to the home in January 2018. They told us this had been delayed to ensure there was a full staff team as they were concerned that due to the staff shortages the staff would not be able to consistently support the new person.

The manager told us that there was a plan in place to review all the care plans to ensure they were person centred and capture the support needs of each person. They told us the previous manager had started this process as it was noted that people's care plans had not been reviewed as per Freeway's expectations. We were told care plans were reviewed monthly with the person and their keyworker, six monthly by the registered manager and annually with the funding authority. At each stage, the person and their key worker were involved. However, it was evident from the quality checks completed by the provider in June 2017 that some people's annual reviews had not taken place since 2015.

The manager told us the care reviews had been now all been planned with the local authority and there was only two to complete and these were organised for the first two weeks in December 2017. Once the reviews had been completed, they were then planning to update people's care plans involving the person and their key worker. The operations manager had been visiting the service weekly to help the team in completing this piece of work. They were in the process of reviewing and updating risk assessments in relation to the home/environment, travel and transport. They were also reviewing all care folders to ensure they contained all the information that Freeways required. Care folders contained an action log on what needed to be done and who was responsible. There was a signing sheet when the member of staff had completed the actions and a section for the manager to review and sign when they were satisfied it was completed. It was evident this work was still in progress. Some of the information in one person's care plans would benefit from a review as it mentioned a staff member that no longer worked in the home and a relative that had deceased. This may cause the person upset if they read their care plan and could be misleading for newer staff who may not know the person's history. The provider had not identified this during the quality check on the care file.

Care plans we reviewed were person centred and contained sufficient information to be able to support the person. Each person had a general file containing the person's care plan, letters and risk assessments, a health action plan file and a file containing key worker reports and daily records. Each person had a personalised daily record, which staff completed in respect of daily activities, personal care, general well-being, any health care appointments attended and outcomes, family contact and progress to any goals they had set. There was some inconsistency in supporting a person brushing their teeth. This was because there were gaps in respect of staff signing to say the person had been supported and, the toothpaste lid had not been put on the tube and the toothpaste had hardened. This would indicate that it had not been used on the morning of the inspection. We brought this to the attention of the assistant manager.

Keyworkers completed comprehensive monthly summary reports from the daily records. This enabled staff to review the care to ensure it was effective and responsive to people's needs. Key workers sat with people to discuss any goals and aspirations they may have. For one person it was to go to Scotland, staff had evidently sat with the person to discuss how they could budget for the trip. To ensure this was clear to staff this should have been formulated into a comprehensive plan for the person. This was because staff may not have the time to read the monthly summary report. We saw there were significant gaps in the completion of the monthly reports and these had not been completed for one person for a period of ten months. The previous registered manager had noted this and the key worker had recommenced in August 2017. The new manager told us moving forward they would be checking the completion of these and would be signing to confirm they had reviewed them.

Daily handovers were taking place between staff. A handover is where important information is shared between the staff during shift changeovers. Staff told us this was important to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach. There was a comprehensive written handover record, which contained information about the happenings of the day, the wellbeing of people, health and safety, cleaning schedules, and temperature checks on food and fridges. This ensured no areas were overlooked as this was all kept in one place. This also enabled staff that had not worked in the home to keep up to date as they could read them on their return to work.

People were engaged in a variety of activities based on their interests and aspirations. Some people attended a day centre operated by Freeways, which was situated at Leigh Woods. Other people went out locally or further afield independently or with staff. People attended a Gateway Club, a social club for people with a learning disability. Activities were discussed during resident meetings and individually with their key worker on a monthly basis. Some people attended the local church on a Sunday. People's cultural and religious needs were recorded in the plan of care. This recognised that people were different and support was unique to them.

Some people had recently been supported to have a holiday as a small group. They had been to Burnham on Sea. People had discussed what they had wanted during a resident's meeting. Those people that did not want a holiday remained in the home with staff support. Whilst people were on holiday, the decoration of the hallway and lounges had been completed.

There was information available for people who were unable to communicate verbally. This included photographs of food, activities and easy read policies such as the complaint policy and safeguarding. We also saw that food menus were pictorial and there were pictorial boards to show who was present in the home. There was one for people by the front door and another for staff. This meant that it was clear who was present in the home and who was out especially in the event of a fire. People could also see who was on duty throughout the day and night.

People had information about the service that was provided in the form of a service user guide. The newly appointed manager told us they were in the process of updating the service user guide and statement of purpose to reflect the change in management.

People were aware of how to make a complaint. Records showed that a number of people had chosen to do this and action had been taken in response to the concern being raised. Some of the complaints related to the environment and staffing, especially where a person had missed out an activity or unable to attend a health appointment because there were insufficient staffing.
Two people had been supported during the inspection to raise concerns. One related to the cleanliness of the home and the other was a person raising a concern about how another person had spoken to them. There was an accessible format for people to complete either by themselves or with staff support. From looking at the records of complaints, speaking with people and staff there was a culture where people were supported to speak out about the service they received.

During the inspection, one person spoke to us about not wanting to live at Underhay House because they did not always get on well with one person. They said they felt this person was telling them off. They said they wanted to live closer to family. The newly appointed manager clearly explained to the person the process including involving a social worker. The person was asked if they wanted support to help with improving their relationships with the other person. It was evident the newly appointed manager was responsive and acting on what they had been told. The person was given reassurance and a timescale when the manager would get back to them.

People' care plans had a section on end of life care where their wishes were recorded. A new format had been introduced, which was more accessible and explored further their wishes. These had not been completed with two people and were blank.

Requires Improvement

Is the service well-led?

Our findings

Over the last twelve months, there have been three changes of manager. The new manager started working in Underhay House on the 27 November 2017 the day prior to this inspection. They had visited the service prior to the 27 November to enable the previous registered manager to handover the service. The previous manager registered with us in June 2017 and left on the 22 November 2017. The newly appointed manager had submitted their application to register with us.

From reviewing the quality checks completed by the provider since December 2016 there was evidence the registered manager employed up until May 2017 had not completed care reviews, supervisions, monitored staff training or completed the provider's own quality assurance checks. The registered manager left Freeways before any appropriate action could be taken. However, from June 2017 an action plan had been developed detailing the actions the new registered manager had to complete to ensure on-going compliance.

When the previous manager took up post at the end of May 2017, they had identified numerous areas that required improvement. They had developed an action to address these shortfalls. From reviewing the action plan it was evident they had addressed some of the areas of concern such as ensuring all staff had received supervision, as these had not been completed since December 2016. They had also updated the health and safety files and other associated documentation including ensuring all staff had taken part in a fire drill. They had also planned annual care reviews, as these had not been completed since 2015 for some people. The new manager told us these had been completed for eight of the ten people. Two people's care reviews were being organised for December 2017. The senior manager told us they were assisting in reviewing and updating risk assessments and monitoring the review of care files. The provider had showed evidence that they had noticed these shortfalls and were following freeways competency procedures before the previous registered manager left the charity. The registered manager who was appointed in May 2017 had completed an action plan to address these concerns.

We saw that there were a number of checks completed by the manager in respect of quality. However, some areas lacked any detail on what the manager was checking for. For example, there was no medication audit to monitor the effectiveness of the system. The manager signed a record but there was no information on what they had checked. There was no central matrix to enable the manager to monitor when a Deprivation of Liberty Safeguard had been applied for, authorised and when it required resubmitting. The manager would have to review each care file to gather this information. There was no central record of when medicine competencies were due for staff again the manager would have to look at each individual staff files. There were no formal checks on the monthly key worker reports. If this was in place the management would have noticed that one person's had not been completed for a period of ten months.

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

The newly appointed manager told us they had to complete a bi-monthly report on a number of areas including complaints, staffing, accidents and incidents and finances. This enabled the provider to have an overview of the service and any risks so these could be jointly managed. In addition, the manager told us they would be receiving monthly supervision from their line manager, which included discussions about care delivery, staff and the general running of the home. They were aware of the systems to monitor quality as they had worked as a trainee manager in another Freeways' home for a number of years. They knew what was expected of them and were evidently aware of the action plan. They were enthusiastic about their new role in developing the team and offering the home some consistency in relation to management support. The manager demonstrated a good understanding of the care and support needs of people living at the home even though they had been in the home for a short period of time. People were actively seeking out the manager to ask questions or seek advice. The manager was supported by an assistant manager. They had been appointed shortly before the inspection but had worked in the home for 18 months as a support worker.

Staff said it had been a very difficult year, with the changes of manager and three staff leaving. They told us about a member of staff that had died, which had an impact on the morale of staff and the people living in the home. We were told this person was instrumental in supporting people to go out regularly and was sadly missed. It was evident people talked about this member of staff from the record of resident meetings. In January 2017 they were talking about putting a memorial plaque in the garden to remember this member of staff. We noted that this had still not been completed during our inspection. The manager told us they were planning to pick up the plaque the week after the inspection and a ceremony organised to remember the staff member.

The changes of manager had also had an impact on a person receiving some equipment that would have been beneficial. From reviewing key worker documentation, it was clearly recorded that since June 2017 a goal had been to purchase a recliner chair for a person to enable them to raise their legs. Staff told us they had been waiting for the provider to agree to the funding.

People's views were sought through an electronic device, which enabled them to answer questions on whether they were happy with the service. The manager said staff tried to use this regularly with people. This was fed directly to the provider for them to collate the responses with a report being sent to the home on a monthly basis. The operations manager told us Freeways were in the process of reviewing this in order to enable people to write more comments rather than relying on a happy or sad face. They said this would enable them to review services more effectively.

The previous registered manager had sent out surveys to family and professionals to gain their views on the service. The new manager told us these were sent out annually to family. There was no evidence in the quality assurance file that these had been sent to family in 2016. The surveys received in July 2017 were positive about the service being provided. Comments included, "Staff knowledge excellent", "Atmosphere friendly and calm" and, "Warm welcome from staff".

Staff meetings were taking place, enabling staff to voice their views about the care and the running of the home. These had taken place in January 2017, June and August 2017. Minutes were kept of the discussions and any actions agreed. These had improved with more detail being recorded in relation to the discussions and any agreed actions since June 2017. The newly appointed manager was meeting up with staff the week after the inspection. An agenda was in place on topics for discussion which included updating care plans, key worker reports and staff responsibilities.

Staff had delegated responsibilities in relation to certain areas of the running of the home such as checks on medicines, care planning and health and safety. The newly appointed manager told us they were planning to review these and ensure staff had sufficient information to enable them to fulfil their role. One member of staff told us, "Generally we work well as a team however, not all staff complete what is expected of them". From talking to the manager, they were aware of this and were planning to put in additional support to ensure all staff knew what was expected of them. Another member of staff said, "It has been difficult at times as each new manager brings in different ideas and expectations". However, from talking with all staff it was evident there was a commitment to providing care that was person centred with the focus on encouraging people to lead the life they wanted.

From looking at the accident and incident reports, we found the provider was reporting to us appropriately. The provider has a legal duty to report certain events that affect the wellbeing of a person or the whole service. There was evidence that learning was taking place to prevent further occurrence, which included looking to see if there were any themes.

We recommend that the service seek advice and guidance from a reputable source, about how from a provider prospective they can monitor the quality of the service involving people, their representative and other stakeholders.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks because staff were not always following the guidelines set down by professionals and risk assessments did not always tell staff what to do in the event of someone not returning to the home. Regulation 12 (1)(2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of the premises were not being adequately maintained in respect of maintenance such as the kitchen worktop and some furniture old and not fit for purpose. Areas of the home were not clean putting people at risk of cross infection Regulation 15 (1) (a) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems for monitoring the quality of the service were not effective in driving improvements and identifying shortfalls. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always supported by sufficient staff that had received training and support through supervision. Regulation 18 (1) (2) (a)