Salutem LD BidCo IV Limited

Birchwood

Inspection report

Birchwood
Fullers Close
Chesham
Buckinghamshire
HP5 1DP

Tel: 01494794112
Website: www.salutemhealthcareltd.com

Date of inspection visit:
09 April 2019
10 April 2019
17 April 2019
30 April 2019

Date of publication:
26 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Birchwood is a care home which accommodates up to 15 people with physical disabilities and sensory impairment. At the time of our inspection 14 people used the service.

People's experience of using this service:
We found breaches of regulations 12, 13 and 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We have made recommendations about risk assessments, safeguarding training, infection control. People were not always protected from the risk of potential harm. Actions taken by the provider in response to allegations of abuse were not always robust, timely or effective to protect people from reoccurrences of these incidents. The service's management of environmental, equipment-related risks and safety checks were inconsistent and did not comply with health and safety requirements. People did not always receive their medicines as prescribed. Medicines were not always stored safely and records were not in line with national guidance. Staff recruitment checks regarding gaps in employment history and disclosure and barring service (DBS) were not always followed-up and risk assessed in accordance with the provider's policy and procedure. People's risk assessments met their individual needs.

We found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The service did not always report notifiable events to Care Quality Commission (CQC) in line with requirements. We found the service had not notified us of nine medicines administration errors which were reported to the local authority safeguarding team. We have made a recommendation about quality assurance and audit processes. Quality monitoring checks did not always effectively identify or address areas requiring improvement. Staff were committed to people using the service and said they felt supported by the current registered manager and team leaders. The service engaged with people to gain their feedback and worked effectively in partnership with volunteers and health and social care professionals to meet people's needs.

We have made recommendations about the environment and facilities of the service to meet people's needs and about equality monitoring for staff. Some equipment was faulty and some people's furniture was in disrepair. The provider had implemented technology to support people's independence. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People received support from staff who received ongoing training, supervision and support.

Staff treated people with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Relatives, relevant professionals and advocates were involved in people's care and treatment.

Care planning documentation was up-to-date and met people's needs. The registered manager and staff demonstrated detailed knowledge of people's needs and preferences. The service accommodated people's interests and facilitated a range of activities. Complaints were logged and investigated.

Rating at last inspection: The service was registered by CQC with a new provider on 30 April 2018. This was the first inspection visit to the service under the new provider.

Rating at last inspection:
The last rating for this service was requires improvement (published 16 September 2017). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected:
This inspection was part of our scheduled plan of visiting services to check the safety and quality of care.

Enforcement:
Please see the action we have told the provider to take at the end of this report.

Follow up:
We will continue to monitor information and intelligence we receive about the service to ensure good quality is provided to people. We will return to re-inspect in line with our inspection timescales for Requires Improvement services.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Birchwood

Detailed findings

Background to this inspection

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

Inspection team:
On the first day of the inspection the team consisted of an adult social care inspector and an expert by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert-by-experience had experience of both residential and community services, caring for older people and people living with dementia. The second and third days of inspection were completed by one adult social care inspector.

Service and service type:
Birchwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates 14 people in three adapted bungalows on the same site.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was unannounced on 9 April 2019. We informed the registered manager we would return on 10 and 17 April 2019. We reviewed further information sent to us from the service on the 30 April 2019.

What we did:
Our inspection was informed by evidence we already held about the service such as notifications about significant events. We checked for feedback we received from members of the public, local authorities, records held by Companies House and the Information Commissioner's Office (ICO). The provider completed a Provider Information Return (PIR) before the inspection. Providers are required to send us this key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We spoke with four people who use the service and four relatives. We observed staff support people at lunch time in two of the bungalows. We observed staff interactions with people throughout our visit and during structured activities. We spoke with the registered manager, three care workers, three team leaders and the area manager. We spoke with two advocates, two volunteers and two healthcare practitioners. We received email feedback from the safeguarding local authority, quality monitoring team and a local authority commissioner.

We reviewed parts of four people's care records including care plans, risk assessments and medicines administration records and other records about the management of the service. After our inspection, we asked the registered manager to send us further documents which we received promptly and reviewed as part of our inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse
• People and relatives we spoke said they felt the service was safe. Staff recognised signs of abuse and relayed the correct safeguarding and whistleblowing reporting procedures. However, we found that in practice people's rights and reporting procedures were not consistently understood or followed; the registered manager informed us staff did not always report concerns about a specific member of staff's conduct because they believed this would be viewed as discrimination against the member of staff.
• Three allegations of abuse about this member of staff were reported by the provider to the local authority safeguarding team and CQC between December 2018 and January 2019 related to discrimination, bullying and harassment towards people using the service. We contacted the service at the time to check people were protected from psychological and physical harm. The area manager informed us the member of staff only supported people in the presence of another support worker, pending the provider's disciplinary procedure. We were concerned this would not prevent reoccurrence as staff presence had not previously prevented these incidents. The area manager said they would review safe measures with the provider's human resources department. However, another allegation of abuse was made before the staff member was suspended from supporting people. During our inspection we found that a complaint about the staff member was made in September 2018 shortly after their employment commenced. The staff member received supervision, but the incident was not reported to the local authority safeguarding team or CQC. Actions taken by the provider were not robust, timely or effective to protect people from reoccurrences of these incidents.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

• Staff received regular online safeguarding training to raise awareness. The provider did not arrange higher levels of safeguarding training for different roles and responsibilities within the service or in accordance with local safeguarding procedures.

We recommend the registered manager attends safeguarding training proportionate to their role, in line with national best practice guidance and local safeguarding policies and procedures.

Assessing risk, safety monitoring and management; Using medicines safely
• The service's management of environmental, equipment-related risks and safety checks were inconsistent and meant people were at potential risk of harm.
• One person using the service told us staff had to transfer kettles of boiling water to their bathrooms for personal care as the hot water outlets were not warm enough and said, "I think that this is dangerous." Staff confirmed this was ongoing for approximately two weeks due to one of the boilers failing, which meant hot

water sometimes ran out in the morning. There was not a risk assessment for interim arrangements pending maintenance work, which was immediately rectified by the registered manager but directed staff to continue to transfer kettles of boiling water. We raised our concerns about the associated hazards and potential risk of harm to people with the registered manager and area manager who said they believed the risk was low. However, hazards such as trips/spills and the needs of people were not effectively identified and alternative safe measures were not explored. We prompted them to review the situation to protect people and staff from the risk of harm. On the third day of our inspection we saw that suitable safe alternatives were in place and staff confirmed these were implemented to avoid the risk of harm.
• The control of substances hazardous to health (COSHH) risk assessment did not effectively identify associated hazards or appropriate safe measures to protect people from the potential risk of harm. Cleaning products were not stored securely in accordance with COSHH regulations and a service safe measure to turn the nozzle of cleaning products to the 'off' position in unlocked kitchen cupboards was not implemented. In response to our findings the registered manager reviewed this risk assessment 24 April 2019 and implemented safe storage of COSHH products. However, hazards were not detailed in response to people's abilities and did not measure the likelihood or severity of risks.
• Legionella preventative measures and safe checks were not consistently implemented. For example, between January and April 2019 hot water and thermostatic mixer value (TMV) outlet temperatures were regularly out of the safe range for the prevention of Legionella and the risk scalds. Remedial work on 8 April 2019 addressed two thermostatic mixer values (TMVs), but this did not account for the out of range hot water outlets. Legionella water sample results (to demonstrate that bacteria counts were within the acceptable safe range) were not on file. The registered manager did not know when these were last completed or what the results were. These were obtained, dated 22 June 2016, and provided to us on the third day of our inspection. The Legionella risk assessment, dated 21 February 2018, did not determine the frequency of sample checks and the provider did not have a schedule in place according to level of risk. The maintenance contractor indicated this should be completed every two years. The lack of robust systems meant the service could not be assured the water was safe. In response to our findings the registered manager promptly arranged for the water to be tested and the results were safe.
• The provider did not arrange timely maintenance works according to priority risk. For example, the service fire assessment and management report, dated August 2018, identified items that were; "high priority - needs to be done ASAP to correct non-compliance." These included compartmentation breaches due to several ill-fitting doors, holes in ceilings around piping, damaged non-fire rated insulation in the loft that was hanging down and posed an ignition risk and storage of combustible materials in the loft. The report rated the overall risk as "medium" based on "possible" risk of "severe injury." The registered manager told us most of the loft had been cleared of combustible materials, but the other actions were not addressed. After our inspection the registered manager confirmed remedial works were booked for 9 May 2019.
• A maintenance record was not available during our visit due to changes in the provider's documentation system. We were provided with a maintenance record electronically after our visit. Some jobs did not have a start date and items listed as 'high' priority did not a specified time frame for completion or interim measures to minimise the impact upon people. The registered manager told us delays to significant maintenance works were due to the provider's contractor not accepting quotes and seeking further quotes which took time. Other low-cost repairs were not always addressed promptly due to local contractors being unreliable.
• We saw that one of the over-track hoists was not operating safely but was still in use. The registered manager was not aware of this and told us it had been repaired the previous week by an engineer. They arranged for the engineer to re-inspect and for a mobile hoist to be used as an interim safe measure.
• People did not always receive their medicines as prescribed. 12 medicines errors in relation to omitted and wrong doses were reported internally since April 2018. No harm was caused to service users and the provider took action to avoid reoccurrence.
• Relevant national guidelines about storing medicines were not always followed. We found medicines

stored in a lockable fridge which was unsupervised and had the key left in it. Prescribed supplements were stored in an open larder next to the kitchen. Fluctuating temperatures had the potential to alter physical consistency of these supplements. The service took immediate action to rectify this immediately. Other supplements were stored securely in a well organised temperature-controlled storage room.
• Medicine administration records (MAR) were completed without gaps. However, we found records were not always in line with national guidance. For example, one service user's allergy was not recorded on their MAR and there were no directions on a MAR for one prescription or a reference to where staff could find guidance. Staff crossed out printed times and hand-wrote prescribed times in accordance with prescriptions and some medicines were handwritten by staff without this being checked and counter-signed. This action was highlighted in a CCG 'self-audit tool' dated, 9 October 2018, but was not implemented. Second signatures were recorded on the MAR where staff observed medicines administration (as part of their training), which could cause confusion as the purpose of the MAR is to record administration and not a training or witness record. The registered manager told us they intended to change pharmacies as the current pharmacy was not able to update printed MAR charts for mid-cycle medicines or change times according to people's needs. They assured us they would arrange for a pharmacy audit to be undertaken as they could not recall when the last audit was completed.

These issues amounted to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

• Staff we spoke with demonstrated thorough knowledge of medicines protocols and knew how to respond appropriately to medicines errors.
• People's medicines care plans were detailed and contained up-to-date information which included a list of current medicines. When required and pain management protocols were in place and regularly reviewed.
• The service had up-to-date risk assessments that addressed people's specific needs such as behaviours of concern, moving and handling, eating and drinking, skin integrity and personal emergency evacuation procedures (PEEPs).
• Risk assessments identified hazards most of the time and rated the risk as "high, medium or low" although the likelihood and severity of risks were not identified. Financial risk assessments did not identify hazards but did have clear strategies to reduce risk. Safe measures to mitigate risk followed the least restrictive principle and considered people's rights and choices.

We recommend the service consistently identifies and documents hazards and the likelihood and severity of risk in line with national guidance.

Staffing and recruitment
• The service had a system to check staff were safe to work before they commenced employment. However, this was not consistently implemented. For example, there were employment history gaps for two members of staff. The registered manager recalled they explored this with one employee and was satisfied with their explanation although this was not documented. Another employee had been authorised to commence work by the area manager without full employment history or the return of their DBS application and without a risk assessment or agreed safe measures. This was against the provider's policy and procedure. One employee had declared a disability but there was no further information about this or whether reasonable adaptations were needed to support the person to perform in their role. Another member of staff's DBS only checked the children's barred list and not adults. This was authorised in writing by the provider based upon the staff member not delivering regulated activities. However, there was no risk assessment to account for unsupervised access to vulnerable adults necessary for them to perform in their role.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

• The rota was based on support hours calculated from dependency assessments to meet each person's individual needs. One to one support for people was allocated in line with their agreed care packages. Staff told us the number of permanent staff had improved this year and there was less reliance upon agency staff which meant there was more continuity of care.
• One person told us there were not enough staff to support them to use the toilet facilities as often as they wanted. The registered manager told us a person's continuing health care funding had suddenly ceased which impacted the number of support hours available. They were supporting the service user to challenge this decision through reassessment.
• There were 11.79 equivalent support worker vacancies, 4.32 of these were covered by the service's casual staff team. An average of 91 hours agency staff per week were used between February and April 2019. Two team leader vacancies were recently recruited to which we were told improved the situation.
• The rota demonstrated a mix of staff skills and experience to make sure there were suitable staff to support people. There were three team leaders who were each deployed to support staff teams in each bungalow. The registered manager said they were training team leaders to deploy support workers effectively as part of their development.

Preventing and controlling infection
• A part time cleaner was in post since February 2019. Service users and relatives felt the service was clean, one person said, "the cleanliness is better since there has been a new cleaner". However, cleaning schedules did not account for all required tasks and records were incomplete. The registered manager identified not all tasks were realistic and planned to implement more effective cleaning schedules. Some cleaning tasks were included in the staff shift plan but tasks such as dining table wiped, kitchen/lounge floors swept were not signed-off as complete and we noted one of the kitchen floors was sticky. Daily health and safety checks in shift plans for equipment such as wheelchairs were not always completed. We saw one service user's wheelchair was unclean.
• We found expired processed meat in one of the kitchen fridges and some other processed meat was not in its original package and labelled as opened 02/04/2019. Staff told us they did not know if this was safe for people to consume and so threw it away.
• The staff toilet/shower was unclean and the bin and sanitary bin were overflowing. A visitor's toilet and one of the kitchens did not have any paper towels. We were told this was because the cleaner had not yet arrived for work to replenish it.
• Most communal areas appeared clean, however, people's private spaces were not. For example, there was a potent odour in one person's bedroom, potentially due to soiled flooring. A bedroom floor was covered in debris, two bathrooms had a build-up of scum on the floor, there was heavy limescale around a bath faucet, patches of mould around a bath, missing tiles on the wall and bathrooms were cluttered with disused equipment. An office chair was stored in one bathroom; we were told the service user prefers to put it there to have more room in their bedroom. There was no consideration of cross-contamination or risk assessment. This meant people were at potential risk of acquiring infections. In response to our findings a cleaning contractor was arranged to deep clean all service users' bathrooms and the staff toilet by the third day of our inspection visit. We were provided with evidence that work was underway to complete maintenance jobs and replace carpets.
• There was infection control guidance for medicines equipment and a completed cleaning schedule for a service user's prescribed inhaler. Medicines preparation areas and equipment appeared clean and protective personal equipment (PPE) was available and used by staff.

We recommend the service follow national infection prevention and control guidance and take action to ensure effective cleaning schedules are implemented and sustained.

Learning lessons when things go wrong

• The service had a system to record and report accidents, incidents and safeguarding events internally that were reviewed and escalated according to risk by the provider. There was a lack of thematic analysis of incidents. For example, there was a focus upon individual medicines errors and staff actions in isolation rather than a review of wider systems, policies and procedures to support staff and reduce the risk of human error.
• Staff we spoke with understood how to report incidents. Incidents were discussed in team meetings and supervisions to encourage reflection about what went wrong and to agree actions to avoid reoccurrence.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The service assessed and documented people's mental capacity and best interest decisions in line with the code of practice. Dates of assessments and the decision maker was not always clearly recorded.
• In some cases, the service asked relatives to sign their consent for people's care and support where DoLS were in place. This was not in line with the code of practice; relatives should be involved in decisions but cannot provide consent on their family member's behalf unless they have lasting power of attorney (LPA) for health and welfare. The registered manager said they would address this and amend documentation.
• DoLS authorisations for service users who met the criteria were on file and applications were followed-up by the registered manager.
• Where people had mental capacity, their consent was sought. Staff received MCA training and demonstrated a sound understanding of how to apply this in practice. We observed that staff asked people for their permission and provided choices about day-to-day decisions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service gathered as much information as possible about people and completed a detailed needs assessment before a new care package commenced.
• Assessments were holistic and identified physical, social and emotional wellbeing needs as well as people's backgrounds, preferences, interests and protected characteristics. For example, people's religious and cultural needs and preference of staff gender were identified and met.
• Care was delivered in line with national guidance and the law. For example, bedrails were audited monthly to ensure they were safe and met people's needs and people's skin integrity was assessed using the

'Waterlow' pressure ulcer prevention tool.

Staff support: induction, training, skills and experience
• People were supported by staff who had ongoing training. Staff received mandatory and specific training to meet people's individual needs.
• Staff received regular supervisions and ongoing practice observations by team leaders and the registered manager to care was delivered in accordance with their training and people's care plans. Safeguarding awareness, staff performance areas for development were evidenced in supervision records.
• Staff received a comprehensive induction, which was completed alongside competency assessments and the care certificate for staff new to care.

Supporting people to eat and drink enough to maintain a balanced diet
• People's eating and drinking needs were assessed and documented. Staff demonstrated knowledge about people's allergies, eating and drinking needs and specialist equipment.
• People and staff told us that menus were not generally followed as people changed their minds and were supported to prepare their choice of food on the day. There was no system in place to check that people's diet was nutritionally varied. The registered manager said they would implement a monitoring system to enable staff to discuss nutritional variety with people.
• A person using the service told us "I like the meals, I can choose my meals." One relative was concerned about their family members weight loss and thought there was not enough fruit available. We observed old dried out fruit in one of the fruit bowls. People's weights were regularly monitored and recorded via Malnutrition universal screening tools (MUST). Referrals to dietitians were made and care plans were followed.
• People generally used their own table rests on their wheelchairs to eat meals according to their needs. There was no central dining table or cues in the space for people to have communal dining experiences. Staff informed us that people generally preferred not to eat together.

Adapting service, design, decoration to meet people's needs
• The design of the building was adapted to meet people's mobility needs and specialist equipment was arranged. However, decoration of the premises and some equipment was in disrepair. Three hoists required repairs which was in progress but delayed due to parts being sourced by the contractor. An assisted bath in a person's ensuite was broken and there were no plans to repair or remove the bath; we were told the person preferred a shower. The registered manager said they would review this with the provider. A relative told us their family member's toilet leaked and there was damp in their bathroom we saw another toilet bowel was broken. Carpets in communal areas and bedrooms were worn and/or stained and there were scrapes on doors and walls that affected paintwork. The service had agreed plans to replace all communal flooring and redecorate paintwork due to start 7 May 2019. There were further plans to replace bathroom and bedroom flooring where needed, and we saw dates arranged for required maintenance repairs.
• The provider had recently invested in adapted specialist technology; we saw this improved people's independence and enabled staff to respond to people's needs promptly. Staff told us they had received training in how to use the technology and demonstrated this to us. One person's call alarm was installed on the wrong side of their bed which was difficult for them reach. The service had identified this issue and workman were on site during our inspection to rectify this.
• People private bedrooms were personalised in accordance with their preferences and were involved in decisions about premises decorations. Some furniture looked tired and two people's chest of drawers were broken with missing drawers.
• People had access to private and communal gardens which were well-kept and had points of interest to meet people's needs.

We recommend the service takes timely action to ensure furniture, decoration, equipment and facilities meet people's needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• A healthcare professional told us the service communicated and co-ordinated healthcare needs effectively and escalated concerns appropriately.
• There were clear care plans to support people with complex and high-risk healthcare needs. The service supported people to access specialist consultants and followed their treatment plans. A district nurse visited one person daily who said they felt their health needs were met.
• Relative said, "They look after [family member's] health needs, I don't worry about this" and "They pretty on the ball with health needs, if there is a problem or an issue a doctor is called."
• People had up-to-date health action plans and medical contact records demonstrated people were supported with regular optician, dentist and GP appointments.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• Staff treated people with compassion and kindness. We received consistent positive feedback from people and relatives such as, "…The staff are kind and caring… It's been the place she has been the happiest at", "The staff are kind, they help me make decisions if I need help" and "I think they are very respectful to [family member's] needs."
• Staff spoke to us about people with respect, empathy and due regard to people's diverse backgrounds. We observed staff engaged with people warmly, at their own pace and checked they had understood the person correctly. One staff member told us, "People have a voice, they arrange what they want to do and are listened to."

Supporting people to express their views and be involved in making decisions about their care
• Documentation evidenced that care plans were regularly reviewed and relatives and other relevant people and professionals were consulted with. We received feedback that the family of one person would like to know more about healthcare appointments and treatment. The registered manager and area manager said this was private to the person who had capacity, however they agreed to clarify expectations and the level of involvement with the family.
• The service arranged advocates for people to promote their rights and involvement in their care and support. One advocate told us that the service kept them up-to-date and involved them in decisions about the person's care and treatment.
• People's care planning documentation included detailed preferred methods of communication and staff strategies to involve people in their care. Staff demonstrated that they understood and implemented people's communication methods. The registered manager told us they intended to source intensive interaction training for staff to increase understanding and encourage people's involvement.
• The service commissioned a speech and language therapist (SALT) to attend the service twice a week. They assessed people's communication needs and provided regular workshops to people and staff which facilitated communication opportunities for people and developed staff skills. We noted that a person who commenced using the service in November 2018 had not received a SALT assessment, although they did have a comprehensive communication care plan by the registered manager. The registered manager said they would co-ordinate the SALT to complete an assessment as a priority.

Respecting and promoting people's privacy, dignity and independence
• Staff respected people's privacy and dignity. Staff were required to complete "Dignity in everyday life" training. One of the team leaders was a 'dignity champion' whose role it was to promote the provider's dignity policy within the service. They referred to national best practice guidance and recently facilitated a dignity coffee morning. People were asked what dignity meant to them which was recorded and displayed

in communal area and discussed in team meetings and supervisions. In response to feedback the team leader helped staff to reflect on their language to be more respectful. For example, instead of "I'm going to feed [person's name]" people preferred staff to say, "I am going to assist."
• People recently took a vote on being called "customers" which was an organisational term and decided to be referred to as "residents". This was being actioned by the service and was fed-back to the provider.
• Staff reported that call alarms installed into people's ensuite bathrooms promoted their independence, privacy and dignity and meant personal care support was less intrusive and more discreet. People could now contact staff for support when they were ready rather than staff waiting directly outside the bathroom door. We observed that one person who was asleep in their bedroom had the door wide open and a member of staff (who was their allocated one to one) sat in the corner of the room.
• Confidential information about people who used the service and staff was protected. We found the service complied with the relevant legislative requirements for record keeping. Filing cabinets were kept locked and keys were held on authorised staffs' person. There was a secure log-in and password protected system to access people's records online.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The provider had an AIS policy in place, but the registered manager was not familiar with this regulation. However, we found that people's communication and sensory needs were identified, recorded and shared and people were supported to access and use specialist communication aids, which we saw in use. The registered manager took action and familiarised themselves with the AIS regulation during our inspection.
• People's needs assessments included comprehensive information about their background, preferences and interests and staff spoke knowledgeably about people and what was important to them.
• A relative told us, "Anything [family member] wants and if they (staff) can possibly get it they will. I think they know my [family member] very well…they try and engage [family member] in activities." A person using the service told us they were always taken to Asda and would prefer a wider range of options and more frequency. There was an advertised driver vacancy since February 2019, which we were told sometimes impacted upon community access. During our inspection people were supported to attend external planned activities and events of their choice.
• Several volunteers provided one to one activities to accommodate people's interests. People were supported to attend church in accordance with their religion and regular group and individual activities were provided. For example, one person participated in the national Boccia team and other people went to adult education courses. The service supported one person to try new activities such as swimming to find out what would they would enjoy.
• There was a decorative art room onsite which appeared to be the 'hub' of the home. Art and craft activities were very well supported by volunteers and appeared to be enjoyed by many people using the service. There were especially adapted easels so people with varying mobility difficulties could be involved. Volunteers organised greeting cards which were copies of people's paintings. There was a planned open day in May where people displayed and sold their artwork.

Improving care quality in response to complaints or concerns
• There was a complaints procedure in place and we saw complaints were logged and investigated. One of the team leaders described that a complaint from a person about being late for college (due to transport issues) led to a staff reflection exercise. The aim of this was to help staff to understand the impact of what went wrong on the person's emotional wellbeing and how to respond in future to ensure people feel listened to and empathised with.

End of life care and support

• The service was not supporting anyone at the end of their life. Staff had undertaken end of life training and supported people to identify their end of life wishes.
• End of life care plans detailed people's wishes and spiritual beliefs and referred to funeral plans. Relatives were involved in discussions where appropriate.
• Not all people wished to engage with end of life discussions. This decision was not documented and the registered manager told us they would do so.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

• The service did not always report notifiable events to Care Quality Commission (CQC) in line with requirements. We found the service had not notified us of nine out the 12 medicines errors which were reported to the local authority safeguarding team. We discussed this with the registered manager who said they were advised by the provider's internal safeguarding team this was not required as the errors did not result in harm to people. We informed the registered manager that any allegations of abuse such as neglecting to administer medicines need to be reported to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

• There was a system in place for checking the quality of the service by the area and quality managers, which fed-into a service improvement plan. However, audits did not always result in effective or timely actions in response to identified areas. For example, a 'service visit report', dated 29 November 2018, identified Legionella safety records and remedial work required action, but this did not result in service compliance. Another service visit report, dated 15 November 2018, stated that medicines errors were reported to CQC, but this was not the case. Audits did not identify gaps in other health and safety checks, or the suitability of risk assessments such as the control of substances hazardous to health (COSSH). Some identified areas resulted in improvements. For example, gaps in people's care planning documentation, bed rail risk assessments and staff training were identified from the previous CQC inspection report. The registered manager took action which met and sustained improvements in these areas.

• Management records were not in good order. Some records were made on loose leaf documents and when we asked to see cleaning and shift planning documentation some dates were missing and documentation was not completed in full. Team leaders were required to check and sign shift plans, but this was not consistently implemented and where team leaders had signed this did not result in complete records. The registered manager said team leaders were developing in their roles and regularly covered vacancies on shift which meant other responsibilities fell behind. Audits dated the 29 November and 7 December 2018 identified that leadership of the service may be compromised by the initial reduction in team leaders and then the induction of newly recruited team leaders. However, there was no contingency or resource identified to support the registered manager until team leaders were recruited to, inducted and signed off as competent in their roles.

• The service archived records every month which meant they were not readily available for us to check. The area manager said this was not in accordance with the provider's policy and procedure for records

retention. Some records were made on the provider's electronic system. However, the registered manager told us they were getting used to the system and could not access everything during our visit. We were provided with required information after our site visit.
• The policy files were not up-to-date with new or rebranded provider polices and procedures and other printed policies were not signed by new staff. The provider stated that all staff had access to the policies on the Z drive. However, the registered manager was not familiar with this and had not encouraged staff to access policies in this way. Some updated policies were uploaded on to the provider's electronic database but there was no system in place to confirm when staff had read these. The registered manager raised this with the provider and we saw evidence electronic records were being developed to allow policies to be marked as read by staff.

We recommend the service seeks advice and guidance from a reputable source and takes action to implement robust and effective quality assurance and auditing systems.

• Staff received equality and diversity training. The registered manager and staff we spoke with had a good awareness of people's diverse needs and measures were in place to meet needs. Where a member of staff had declared a disability on the provider's equality monitoring form there was no evidence this was explored with them or whether reasonable adjustments were required.

We recommend the service seek advice and guidance from a reputable source about equality monitoring and provider responses to support employees.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
• Staff, relatives and advocates told us the quality of the service had improved under the leadership of the current registered manager and team leaders, with comments such as "[The registered manager] came into a rescue job, there have been times (in the past) where there wasn't enough qualified support. It is much better now with the team leaders being strong, personable, and wanting to help", "[The registered manager] is very dedicated, always here, always trying to upgrade and improve, nothing is a silly question, (they) seems to know everything, and works alongside us when we're short staffed" and "They have good quality staff there, it's on an upward swing." The registered manager demonstrated detailed knowledge about people's care and treatment and had close oversight of health appointments and outcomes to meet people's needs.
• Support staff said they felt valued by the registered manager and were committed to people using the service. One staff member reflected, "We have paperwork issues, but we have a lovely set of staff as they put the residents first, above everything else." We were made aware that staff volunteered in their own time to support people on day trips and to access medical appointments.
• The registered manager was aware of their duty of candour responsibilities. Incidents were investigated and people were notified and received an apology when things went wrong.
• The service had a business contingency plan which included recruitment and the supply of medicines and goods in in relation to the government's guidance about a potential 'no deal' EU Exit. Information was displayed about the "EU Settlement Scheme" for EU nationals in line with the government's draft "Withdrawal" agreement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The service sent annual surveys to people, which were due to be sent April 2019. The last survey was comprehensive and analysed people's views which fed-into the development of the service. For example, the service took action to promote dignity and respect explored a wider variety of activities and community

access. The registered manager intended to extend surveys to relatives in future to seek feedback from their perspective.
• Regular residents and team meetings were held to share information and gain feedback.

Working in partnership with others
• The service coordinated several volunteers who supported people to engage in activities and supported the service with specific projects important to people. For example, volunteers improved the outside space and make it accessible and safe for people to enjoy. The service also accessed voluntary engineers to make and repair bespoke communication aids which were not available through the NHS and meant people's individual communication needs were met.
• The service worked with a person's previous educational placement to further explore ideas to support the person reach their full potential.

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 18 Registration Regulations 2009 Notifications of other incidents The service did not always report notifiable events to Care Quality Commission (CQC) in line with requirements. We found the service had not notified us of nine medicines administration errors which were reported to the local authority safeguarding team.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service's management of environmental, equipment-related risks and safety checks were inconsistent and meant people were at potential risk of harm. For example, Legionella safety checks were not completed or responded to effectively. The control of substances hazardous to health (COSSH) were not appropriately risk assessed for hazards according to the abilities of people using the service. 'High Priority' maintenance works such as fire safety remedial works were not planned or completed in a timely manner according to risk. People did not always receive their medicines as prescribed. Medicines were not always stored safely or securely and records were not in line with national guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

People were not always protected from the risk of potential harm from abuse. Actions taken by the provider in response to allegations of abuse were not always robust, timely or effective to protect people from reoccurrences of these incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment checks regarding gaps in employment history and disclosure and barring service (DBS)were not always followed-up and risk assessed in line with the provider's policy and procedure.