

Innowood Limited

Kingswood House Nursing Home

Inspection report

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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

We carried out a comprehensive inspection of Kingswood House on 17 and 18 April 2018. The inspection was unannounced.

Kingswood House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Kingswood House is registered to provide accommodation for people requiring nursing or personal care and treatment of disease, disorder or injury for up to 22 people and younger adults with mental health support needs. At the time of the inspection there were 22 people living at Kingswood House.

There was a manager in post who was currently in the process of applying to be the registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was fulfilling the role and responsibilities of the registered manager until they were formally registered.

We last inspected the service in August 2017. At that inspection, we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a warning notice to the provider asking them to take immediate action in respect to the following issues; Risks to people's health and safety were not adequately assessed and action was not being taken to do all that is reasonably practicable to mitigate risks including; risks from insufficient fire safety and infection control measures at the premises, risks of pressure damage and injury from incorrectly fitted lap belts to people. Systems or processes to assess, monitor and improve the quality and safety of the services provided were not operating effectively.

We also asked the provider to make improvements to address the following issues; People's care and treatment was not always being provided with their consent and the provider was not always acting in accordance with the Mental Capacity Act (MCA) 2005. Premises and equipment used by the service was not always clean, suitable for their purpose and properly maintained.

At this inspection we checked to see if the provider had taken actions to address these issues.

The provider had implemented control measures to reduce the risk of infection. However, issues with the staffing arrangements and people's behaviour were impacting on the effectiveness of the measures at the time of this inspection and this required improvement. The manager was aware of the issues and was acting to address this.

Systems and processes were operating effectively in assessing and monitoring quality and safety of the service. Where areas of practice required improvement and effective action had not yet been completed, evaluation and learning based on current performance was taking place to drive on-going improvement and avoid future delays.

There was a planned schedule of works in progress and other actions had been implemented to ensure premises and equipment were suitable for purpose and properly maintained.

Risks to people's health and safety from insufficient fire safety measures, risks of pressure damage and injury from incorrectly fitted lap belts to people had been effectively addressed. People's support was appropriate and being provided with their consent, in accordance with the principles of the MCA.

Ordering, disposal and storage of medicines was being carried out safely. However, medicine recording systems were not always managed properly and guidance for people's 'as and when' (PRN) medicines lacked detail about when these should be administered.

People told us they felt safe. The service had enough staff and there were safe recruitment practices. Risk assessments were in place that identified any potential hazards to people's well-being. Risks to people were monitored and staff knew how to support people to safely manage them.

Some risk assessments contained more guidance about how to manage risks safely than others. The manager was aware of this and was in the process of rewriting risks assessments for all people and transferring them onto a new electronic system to make them more accurate and easily accessible for people and staff.

There were systems and processes to keep people safe from abuse. People were protected from discriminatory abuse and supported to know how to recognise abuse and what help they could receive.

The service was effective and helped people to achieve good outcomes. Holistic assessments of people's needs were carried out to ensure staff knew the support people wanted and needed. People and if necessary other relevant people, such as health and social care professionals were involved in this process.

Any care and support decisions related to any protected characteristics under the Equality Act 2010 were recognised and respected. People were supported effectively with their eating and drinking, medical and health care needs.

Staff worked well internally and externally to deliver effective support and treatment to people. The service shared information and worked with other agencies to co-ordinate people's support so it remained consistent and effective.

Staff received regular training and supervisions to enable them to deliver effective care. The service kept up to date with best practice guidance and shared this with staff. Rotas were arranged to ensure suitably experienced, trained and skilled staff were always available.

Where appropriate, people had been involved in making decisions about the environment. There were further plans in place to adapt parts of the premises to better meet people's individual needs and promote their independence.

Staff were caring and involved and treated people with compassion, dignity and respect. People told us they

were free and able to make their own choices and could talk to staff about what they wanted to do and how they spent their time.

People were encouraged to be as independent as possible. Staff told us, "I like working at this service compared to others I have been at where it is more institutionalised. They promote independence here".

The manager told us that the service looked to support people through a rehabilitative model of care. The service always looked to provide people with a programme of support that focused on empowerment and independence. They said, "We are not just here to give people medicine".

The service was responsive and had recently invested in new resources and systems to ensure that they could sustain and build on providing good quality personalised care. People told us they had been involved with the planning of their care and that their care was discussed and explained to them by staff. This allowed people's choices to be respected as much as possible.

Staff knew people and the support they needed well. Care plans were in place for people and covered in broad detail information about people's personal background, relationship information and their support preferences, including their likes and dislikes.

Some care plans contained more detail than others about people's personal information and how to meet their needs in an individually responsive way. The manager was aware of the was currently revising and transferring people's paper based care plans to an electronic system to address any gaps in plans.

A dedicated activities team had been recently created and used information about people and the support they wanted and needed to create weekly individual and group activity schedules. These were used to ensure people had responsive support take part in personalised, appropriate and relevant activities.

A recent change in management had been positive and had helped to create a supportive and open team culture. Staff well-being and equality rights were respected. One staff said, "We have a good team and we get on well. I can be open". Another staff member said they felt they were valued.

The service had a clear vision of enabling people to achieve their preferred outcomes and goals in life through receiving holistic and therapeutic support. Staff received effective support to understand their roles and the values they needed to display to realise this vision.

The service worked well with partnership agencies to help deliver high quality care for people. Staff and people's involvement in helping to develop the service was encouraged.

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.

Management of medicines and infection control was not always effective.

People were protected from the risk of abuse, including discriminatory abuse.

Risks to people were assessed and managed safely.

The service had enough staff to meet people's needs safely.

Is the service effective?

Good ●

The service was effective.

People were supported to achieve good outcomes.

Staff had the right skills, knowledge and experience to meet people's needs.

People received support in accordance with the principles of the Mental Capacity Act (MCA) 2005.

People's health care needs were met.

Is the service caring?

Good ●

The service was caring.

Staff were kind and compassionate.

People's privacy and dignity was respected.

Staff promoted people's choice and independence.

People were involved and expressed their views about their support

Is the service responsive?

Good ●

The service was responsive.

People received personalised care.

Staff responded to changes in people's needs.

People had support with meaningful activities.

Complaints were managed appropriately.

Is the service well-led?

The service was not always well-led.

Action had not always been taken in a timely manner to address all areas of practice that required improvement.

The service had a positive, supportive and open culture.

The service worked well with other partnership agencies.

People and staff were encouraged to help develop the service.

Requires Improvement 

Kingswood House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 18 April 2018 and was unannounced.

The inspection team consisted of an inspector and an expert by experience on 17 April and two inspectors on 18 April. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

For this inspection we did not request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

We spoke with 5 people living at the service. We spoke with 3 support workers, the activities co-ordinator and the clinical lead nurse. We spoke with the chef, the service manager, the area manager and the registered provider. We also spoke with a visiting social care professional.

We reviewed care records for four people and 'pathway tracked' two of them to understand how their care

was being delivered in line with this.

We observed the support that people received in the communal areas including lounges and dining areas of the service.

We reviewed staff training, supervision and recruitment records, medicines records, risk assessments, and accidents and incident records. We also reviewed complaints and compliments documents, quality audits, policies and procedures, staff rotas and other records related to the management of the service.

Is the service safe?

Our findings

Most people told us that they thought the service was safe. One person said they could tell a member of staff if they did not feel safe. A visiting social care professional told us that they had been visiting the location for many years to review people's support packages. They said that during this time when talking with their clients, "No one has ever said they felt unsafe". We found management of medicines and infection control were areas of practice that required improvement.

Following the last inspection in August 2017 we issued a warning notice to the provider asking them to take immediate action in respect to the following issues presenting serious risks to people's safety; insufficient fire safety and infection control measures at the premises and risks of pressure damage and injury to people from incorrectly fitted lap belts. At this inspection we looked to see if the provider had acted to address these issues.

At the last inspection we also identified the following issues regarding people not being protected adequately from risk of infection; unclean physical environment and lack of hand washing and drying facilities in communal bathrooms. Cleaning equipment was not maintained or stored correctly.

At this inspection, we saw that the provider had implemented control measures to reduce the risk of infection. However, issues with the staffing arrangements and people's behaviour were impacting on the effectiveness of the measures and this required improvement.

The provider had implemented regular infection control audits that helped identify issues and put in place actions to help maintain a clean and hygienic environment. There were separate cleaning staff with specific responsibilities and a set schedule of tasks to follow for maintaining cleanliness across the service.

Staff used personal protective equipment (PPE) such as plastic gloves or aprons when supporting people with personal care. Cleaning equipment was maintained and stored correctly. Bathrooms contained paper towels and driers along with soap so people could wash and dry their hands after using the facilities. This helped prevent the spread of infection.

However, we found that the service was not always clean during our inspection. Some areas of the premises were dirty, including urine on the upstairs landing and on the floors of communal bathrooms. This presented an increased risk of infection to staff and people using the service. We identified this as an area of practice requiring improvement.

We discussed this with the manager, who told us that currently the service was under recruited for cleaning staff. The service had been experiencing high turnover of cleaning staff for a period and a cleaner had also recently left at short notice. This had impacted on the ability of the service to maintain a clean environment as, over time, the schedule of cleaning tasks had not always been consistently completed.

Some people using the service displayed behaviours that contributed to an unclean environment regularly throughout the day. For example, cleaners could clean bathrooms and wash floors upstairs and then finish for the day. A person may then display behaviours that caused the floor to become unclean or the bathroom to become dirty.

People would not alert staff after causing these incidents. Staff carried out routine checks on cleanliness throughout the day on an as and when basis. If it was seen or reported that areas of the house were unclean, staff cleaned them immediately. However, people causing the incidents were not receiving 1:1 support and the premises was large. This meant areas of the service may be unclean for varying periods of time until it was recognised by staff or reported by other people using the service.

The manager was aware this was an area of practice that required improvement and of the need to further reduce the risk of infection these issues presented. They planned to act to address the issues. The manager would increase spot checks so these were taking place more often. They had recently recruited to the cleaning staff vacancy and planned to use current staff to backfill the position until they could start. This would help ensure that, moving forward, all infection control tasks were completed in a timely manner to keep the service clean and hygienic.

The service was also liaising with health and social care professionals to address the root cause of people's behavioural issues, with a view to supporting them to prevent incidents that caused the service to become regularly unclean throughout the day.

At the last inspection, the service had not been meeting the requirements of Regulation 12 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014 in relation to fire safety in consecutive inspections in August 2015, April 2016 and August 2017.

At the last inspection in August 2017 we identified the following issues as presenting a high fire risk; People smoking in their rooms was not being monitored and managed effectively. Lack of suitable disposal containers for cigarettes in designated and non-designated smoking areas. Fire extinguishers were being regularly removed from walls by people. There was a lack of detail in people's personal emergency evacuation plans (PEEPs) about how to safely support people to evacuate the building in the event of a fire.

At this inspection we found the provider had taken sufficient action to address fire safety issues and reduce the risk of fire occurring. All fire extinguishers were now secured to mitigate the risk of people removing them. Designated smoking areas were situated in the garden and on fire escapes on each floor. It had been agreed with the fire service that the use of fire escapes for smoking was a safe enough thing to do, providing fire doors leading to the escape were not left propped open.

Metal bins had been installed in smoking areas and were used by people to extinguish their cigarettes safely. Some metal bins were periodically removed by a person and these were in the process of being secured to prevent this from happening.

Internal fire risk assessments regarding people smoking in their rooms had been reviewed. The service now operated a strict no smoking in rooms policy. All people had been informed that if found smoking in their rooms they faced the possibility of immediate eviction. Regular room checks were taking place. Staff were immediately confiscating any sources of ignition and flammable materials if people were suspected or found to be smoking in their rooms.

People's PEEPs and general service evacuation plans had been reviewed and contained details about how

to safely support people to evacuate the building in the event of a fire. We saw evacuation drills had been completed in January and March of this year to help staff practice how to put these contingency plans safely into practice if a fire broke out. Regular fire alarm, fire door, fire extinguisher and emergency lighting checks took place to ensure these systems were operating effectively.

A fire risk inspection and assessment of the premises had been carried out by an accredited fire safety organisation and the local fire rescue service following the last inspection. We saw a confirmation letter from the fire service dated September 2017 stating that following action from the service to address issues they had identified, they viewed the service as compliant with fire safety regulations.

Further non-urgent control measures needed to manage the risks of fire at the premises had also been identified in the fire risk assessment and fire service inspection. These actions were underway and scheduled for completion within the designated timeframes. This included a sprinkler system linked to the fire alarm throughout the property that was in the progress of being installed.

At the last inspection we identified the following issues regarding risks of pressure damage and injury to people from incorrectly fitted lap belts; staff were not aware of the risk to people from slipping down and falling out of wheelchairs where lap-belts were incorrectly used, fitted or maintained. People with lap belts did not have risk assessments or care plans completed to ensure they were safe when using their lap belt. People at risk of pressure damage had no care plan or risk assessment to direct staff on how their risk was to be reduced.

At this inspection we found the provider had acted to address these issues. People had risk assessments in place for lap belts on wheelchairs. Staff were aware of why lap belts were there and how they should support people to use them. People had been assessed using a pressure damage risk assessment tool. This identified preventative actions to mitigate the risk. These actions were recorded in people's care plans and followed by staff when supporting people.

People told us they did not have any concerns about their medicines. People had been assessments in place detailing the level of support they needed to take their medicines safely. Medicines were stored safely and securely. Registered nurses were responsible for administration and management of medicines and had received training to do this safely. There was an electronic system in place to help with managing ordering, administration and disposing of medicines safely.

However, we found that medicine recording systems were not always managed properly and guidance for people's 'as and when' (PRN) medicines lacked detail about when these should be administered. We identified these areas of practice as requiring improvement.

The electronic Medication Administration Record (MAR) system included information about people and the medicines they needed, including details about how their medicines should be taken or used and how often. Staff scanned medicine box labels onto the system when people's medicines were due to be taken. The system then confirmed the type and dose of medicine, the person the medicine had been prescribed for and instructions for administration. Staff then recorded on the system that the medicines had been given. This ensured people got their medicines as intended and this was recorded appropriately.

However, we sampled the electronic MAR records and found there were gaps in administration records for several people that had not been accounted for, over a period of several months. These gaps had not been recognised or investigated by the Registered Nurses responsible for medicines. This meant it was not known if people had received their medicines.

Some people were prescribed medicines on a 'when required' (PRN) basis if they needed them. PRN guidance was in place for some people who were prescribed PRN medicines. Some PRN guidance contained more detail than others when describing the requirements for when staff should offer and administer these. This inconsistency increased the risk that people may not receive their prescribed PRN medicine as intended.

We identified these as areas of practice that required improvement and discussed these issues with the manager. They took immediate action to update PRN profiles and carry out an audit to investigate the unaccounted-for medicines. The manager confirmed the causes of the unaccounted-for medicines following the inspection as staff recording errors due to their misunderstanding of how the system operated. It was also confirmed that some medicines showing as unaccounted for were the result of a technical issue.

The manager acted to re-train the registered nurses and staff who had made recording errors. They contacted the company who operated the electronic system to rectify the technical fault. Management audits of medicines had been carried out every four months, but these were now planned to take place more frequently. This would help mitigate against delays in recognising any future errors.

People had risk assessments in place that identified any potential hazards to their well-being. Some risk assessments contained more guidance about how to manage risks safely than others. The manager was aware of this and was in the process of rewriting risks assessments for all people and transferring them onto a new electronic system to make them more accurate and easily accessible for people and staff.

The manager, clinical lead and nurses monitored risks to people daily. They kept staff informed with regular and detailed updates during handovers or following discussions with relatives and health professionals about how to manage any risks. Staff confirmed they knew about risks to people and could explain how they supported people to manage them.

Staff completed daily notes and specific accident and incident forms. Any notable incidents were reported to the manager, clinical lead or nurses. These reports were reviewed and actions agreed and implemented to keep people safe. The actions and learning from incidents were discussed with staff and put in place. This helped them to know the right support needed to keep people safe and to look at how to reduce the risk of incidents happening again.

There were systems and processes to keep people safe from abuse. Staff received safeguarding training and knew how to recognise and report any signs of abuse to help stop or prevent this. The service had an equality and diversity policy in place and staff were aware of the importance of protecting people from all forms of discriminatory abuse. There were 'resident forums' held regularly and topics discussed included helping people recognise abuse. This helped people to know what to do and who they could contact for support if they found themselves a potential abuse situation.

The manager worked in partnership with relevant partnership agencies in response to any safeguarding concerns to agree a plan to keep people safe. For example, a person involved in incidences of substance misuse on the premises was referred for a multi-disciplinary agency review. Support and control measures by each of the different agencies were agreed to help the person and keep them and people at the service as safe as possible.

People told us the service had enough staff and were available to help them if they needed them. There had been some recent turnover with staff but the service was currently fully recruited. The rota showed sufficient staff had been delegated to meet people's needs. Tasks were allocated by the clinical lead and registered

nurse at each shift to make sure people's needs were met.

There were safe recruitment practices. All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses will have up to date nursing knowledge and skills and uphold the expected professional standards.

All staff had undertaken a satisfactory Disclosure and Barring Service (DBS) check before being formally offered a job. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Staff files showed staff had provided an application form, two references and passed an interview before starting work. Staff also had to then complete further training and a competency based induction and probation period before being offered a permanent position.

Is the service effective?

Our findings

People told us that the service was effective and that staff had the right skills knowledge and experience to meet their needs. A visiting social care professional told us the service was good at meeting people's needs. They said, "This is a valuable service. They accept people with different needs and can meet these. All my clients have been here for a substantial amount of time". We found that the service was effective and helped people to achieve good outcomes.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in line with their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we identified that mental capacity assessments were not decision specific. This meant that some people were not consistently supported in consenting to all aspects of their care. There was not always evidence that decisions made in people's best interests were the least restrictive possible. This meant people were at risk of having their liberty unlawfully deprived. At this inspection we looked to see if the provider had acted to address these issues.

Assessments of people's mental capacity to be able to make specific decisions had been carried out. If people were not able to make decisions in some aspects of their lives, relevant people with the right authority, such as mental health professionals or independent mental capacity advocates, had been identified to act in people's best interests to help ensure the right decisions were made for the person. People's told us when they had consented to their care or where they were aware of decisions had been made in their best interests and who had done this.

There was a 'Consent to Care and Treatment' document in place. This was designed to evidence that people, or a relevant person acting in their best interests, had been consulted and agreed to their care, including where decisions were made on their behalf where they lacked capacity. However, 'Consent to Care and Treatment' documents were not always signed to evidence this process had been followed. The manager was aware of this as a historical issue. They were currently completing a transition to a new care planning system that would document correctly that people would be receiving the right support to make their own decisions, in line with the principles of the MCA.

Staff had received MCA and DoLS training. Not all staff we spoke with were confident about explaining the consent and decision-making requirements of this legislation. However, staff had a good awareness of people's individual capacity and could explain when it was appropriate to support them to make their own

decisions and how they did this. We raised this with the manager who acted to re-visit the principles of the legislation with staff to help ensure they understood the link between these and their practice more explicitly.

The correct process for assessing and submitting applications for DoLS them had been followed and authorised DoLS were in place for people who required them. Any conditions on authorisations to deprive a person of their liberty were being met. The manager was aware of any potentially restrictive practices in place to protect people's best interests. All restrictive practices were proportionate and were monitored by the manager. This helped ensure people and staff were kept safe in ways that avoided the use of restraint as much as possible. For example, ensuring that physical support for people with challenging behaviour was only used as a last resort.

At the last inspection we identified that the premises and equipment used by the service was not always clean, suitable for their purpose and properly maintained. Many areas of the premises required maintenance and decoration. Fixtures in bathrooms and furniture coverings were damaged and as a result it was not possible to ensure these were kept clean. At this inspection we looked to see if the provider had acted to address these issues.

A schedule of works to address maintenance and decoration issues at the service was in progress. Some issues, such as decorating communal rooms and hallways, replacing flooring and repairing fixtures in bathrooms had been completed. Other work such as maintenance to plasterwork, replacing doors and furniture and replacing furniture and carrying out repairs in the garden courtyard was underway or planned to begin soon.

Recent health and safety and maintenance audits had been introduced and were being carried out regularly by the manager and area manager. The service had employed a maintenance staff member who was available on-site. This helped to make sure that any urgent environmental issues could be identified and addressed in a timely manner.

Where appropriate, people had been involved in making decisions about the environment. For example, following a 'residents' forum', people had chosen the colours they wanted the lounge to be re-decorated in. New furnishings and decoration within inside and outside communal social spaces enhanced people's quality of life by allowing people to feel more comfortable and have a better experience when accessing these spaces to see other people and visitors, or carry out activities.

There were further plans in place to adapt parts of the premises to better meet people's individual needs and promote their independence. For example, an upstairs room was due to be adapted to create an 'Independent Daily Living Room'. This would create a separate space from the laundry which was presently only accessed by staff on behalf of other less able people. People would then have their own space be able to do their own laundry. There were also plans to adapt the access to the kitchen, so people could have access to equipment to make their own meals. These environmental changes would help people learn new skills and be as independent as possible.

The manager, clinical lead and registered nurses completed an assessment of people's physical, psychological and social needs. Where appropriate, relevant health and social care professionals were also involved in this process. This helped all relevant information about people was shared to make sure they received the support they wanted and needed.

The service employed a recognised outcomes assessment and measuring tool called the 'Recovery Star',

which was developed by the Mental Health Providers Forum. The star contains ten main areas of people's lives, including social networks, living skills, identity and self-esteem, trust and hope and physical and mental well-being. Goals corresponding to each area were set by the person and relevant people involved in their care. This identified people's preferred support outcomes in a holistic manner.

Once people had set their goals, the relevant support they needed to achieve them was also identified. The holistic nature of the tool helped to ensure that any care and support decisions related to any protected characteristics under the Equality Act 2010 were recognised and respected. At the time of the inspection, the outcome assessment tool had only recently been introduced. However, moving forward recovery star could be used on an on-going basis to record how people are progressing towards their goals and measure how effective people's support was.

Staff worked well internally and externally to deliver effective support and treatment to people. The service shared information and worked with other agencies such as community mental health and social care professionals when people were referred to their care or when people were leaving to use another service. This helped co-ordinate people's support so it remained consistent and effective.

The manager had recently revised the structure of the staff teams so there was a balance of registered mental health nurses (RMNs), registered general nurses (RGNs) and support workers working directly with people throughout each shift. There was also now a three-tier key working system where each person had an RMN, RGN and support worker assigned as their personal key working team. The promotion of an integrated health and social care approach within the service maximised the different skills and knowledge of staff from different professional disciplines. This helped ensure people's needs could be met holistically and they could achieve effective outcomes.

At the last inspection we recommended that the induction for new staff be amended to conform to current best practice guidelines. This was made to ensure new staff are sufficiently supported in their roles to effectively meet people's needs. New staff now received an induction that met the Care Certificate standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve.

Staff also received regular training to enable them to know how to meet people's needs. Staff could ask for additional training if they felt they needed more knowledge in any areas of their role. Alongside training opportunities, staff received regular supervisions and appraisals. Supervisions were carried out in line with the Skills for Care, 'Common Care Principles'. These are principles that had been developed to allow staff to develop the underlying skills needed to deliver excellent support in health and social care services.

The manager was a RMN and kept up to date with Royal College of Nursing updates as well as the latest advice and information from the National Health Service, National Institute for Clinical Excellence, Skills for Care and local authority provider forums. This information was shared with staff via regular updates and in supervisions to help them keep up to date with all relevant best practice guidance. This helped enable staff to consistently deliver effective support.

People were supported with their medical and health care needs. Staff monitored people's health regularly. On site nurses offered medical advice and treatment or could support people for referral for specialist health care if needed. People had support to understand the information and explanations about their treatment. People had support to attend appointments or arrange visits from specialist health professionals, such as psychologists and psychiatrists, so people received timely support with their healthcare needs.

People told us they had enough to eat and drink and the quality of the food was good. The chef attended 'residents' forums' and people could talk to them about their preferred menu choices, which were accommodated as much as possible. People's nutritional and fluid needs were assessed. Where necessary, people had been referred to specialist healthcare services such as dieticians or speech and language therapists. This information was shared with the chef and staff and implemented to provide the most effective support for people with complex eating and drinking needs.

Is the service caring?

Our findings

People told us they thought staff were kind. One person said staff "Certainly" knew how to care for people and that staff were, "Always willing to help". We found the service was caring and involved and treated people with compassion, dignity and respect.

At the last inspection we identified that the service required improvement as some people said they felt they could not choose certain aspects of their care. This included several comments about not being able to choose when they could go out of the home, due to a locked front door that only staff had access to the code for. At this inspection we looked to see if the provider had acted to address these issues.

The front door remained locked using an electronic keypad that only staff had access to the code for. This measure was in place as some people had an authorised DoLS restricting their access to go outside without support. This was to help the people remain safe. The code was not shared with other people due to the risk that this would become known to people outside of the service who could then potentially gain access to the property and engage in criminal activities.

People had been told and agreed to the current door code policy. The service was staffed 24 hours a day and if people without an active DoLS authorisation wanted to leave they could ask a staff member to open the door. No one told us they felt they could not choose to go out if they wanted. People said they went out frequently and this was not an issue. One person said staff would help them "Any day" to leave whenever they wanted.

The manager was currently working with the DoLS team to explore further options as to how they could meet the condition of restricting access for some people, managing safety risks and be able to empower others to be able to leave without speaking to staff.

People told us they were free and able to make their own choices and could talk to staff about what they wanted to do and how they spent their time. One staff member told us they helped support people to be actively involved in decisions about their care by always, "Give people choice and explore options with individuals".

People were encouraged to be as independent as possible. Staff told us, "I like working at this service compared to others I have been at where it is more institutionalised. They promote independence here". The manager told us that the service looked to support people through a rehabilitative model of care. The service always looked to provide people with a programme of support that focused on empowerment and independence. They said, "We are not just here to give people medicine".

People told us they felt they could always do as much as possible for themselves if they were able. Staff told us that they considered everyone's levels of independence, confidence and ability when supporting them to allow people to be as independent as possible. For example, one person had been supported to learn how to administer their own medicine after it was recognised that this was a task they could do without staff

support. Other people regularly made their own breakfasts and other meals.

People told us that they felt staff helped them to remain as private as possible when they were supporting them. People said their rooms were private. One person told us, "Staff always knock on my door and wait for an answer". Staff told us they always respected people's dignity. For example, staff would only offer encouragement and assistance with tasks such as personal care and changing beds for people who required this level of support.

The service had confidentiality, data protection and record keeping policies in place that the manager, staff and people were all aware of and adhered to. This ensured people's personal information was correctly stored, used and shared.

People said staff talked with them in a way they liked. We observed staff acknowledging people and talking in a friendly and relaxed way with them. Staff were patient and made eye contact when speaking with people. If people required longer to formulate sentences, staff waited for them to talk in their own time and did not respond on their behalf. For people who required it, staff used simple language and shorter sentences. This helped make sure that people could understand them.

When a person became distressed and began to raise their voice, staff responded quickly and in a kindly and compassionate manner. They took time to enquire about the cause of the person's upset, offer reassurance and then engage the person in a more general conversation. This gently de-escalated the person's distress until they were talking calmly with the staff member and the issue was resolved.

People said staff had time to talk with and listen to them in a personal manner, "In the evenings some staff will sit and talk with me". Staff used planned keyworker meetings to do this, as well as taking time when they could throughout their shifts to share information and listen to and answer people's questions about their support. There were also opportunities for people to be updated and included in what was going on at the service at 'residents' forums' and other service meetings.

Is the service responsive?

Our findings

People told us that they thought the service could meet their needs in the way they liked. A visiting social care professional said they thought the service was, "Good at tailoring support to people and know them well". We found the service was responsive and had recently invested in new resources and systems to ensure that they could sustain and build on providing good quality personalised care for people.

At the last inspection we identified that the service was not delivering person centred care to people and this required improvement. People did not have care plans that outlined who they were as a person, what their aspirations were and the support they needed to achieve their life goals. This meant that people were not receiving support with meaningful social activities inside and outside of the service. At this inspection we looked to see if the provider had acted to address these issues.

People told us they had been involved with the planning of their care and that their care was discussed and explained to them by staff. This allowed people's choices to be respected as much as possible. If necessary people with authority to act on people's behalf, such as health and social care professionals, were also involved in the care planning process. This helped make sure staff knew about people's strengths and levels of independence and could support them to achieve the best possible quality of life.

Following the initial assessment, using the 'Recovery Star' process, information about people's physical, mental, emotional and social needs was recorded in a care plan to record what their needs were and how they would like to be supported. Care plans were in place for people and covered in broad detail information about people's personal background, relationship information and their support preferences, including their likes and dislikes.

People's care plans also included details about how people's support needs reflected any protected characteristics under the Equality Act 2010. For example, one person's plan included relevant details regarding their sexual orientation and how this informed their social and relationship preferences.

Some care plans contained more detail than others about people's personal information and how to meet their needs in an individually responsive way. The manager was aware of this and the service was currently transferring people's paper based care plans to an electronic system. As part of this process, where plans lacked information this was being added to help staff know how best to provide person-centred support for people. Plans were also being more specifically linked with the recovery star outcome assessment and monitoring planning tool. This would help to further ensure people had as much choice and control over their support as possible.

While plans were being amended and revised and the new care planning system was implemented, staff could confirm they were confident they knew people well and how they liked to be supported. Alongside existing information, staff could talk to people, other staff and other relevant people involved in people's care to make sure they understand how to offer person centred support to people.

Everyone knew they had a care plan and people told us staff had showed this to them whenever they wanted. The service upheld the principles of the Accessible Information standards (AIS). Staff were committed to supporting the information and communication needs of people with a disability or sensory loss to access information about their support in the most accessible way.

Although not necessary for people using the service at the time of the inspection, staff could explain how they would meet AIS principles. For example; by printing off easy read or large font copies of care plans for people with vision impairments, or providing or reading aloud concise versions of support information for people with reduced intellectual capacity.

Reviews of people's support needs took place regularly. Some people engaged with the review process more than others out of choice. There was also regular handover of information about people in daily notes and handovers, or following meetings with other health or social care professionals. This meant staff could respond quickly to make any necessary changes if there had been an increase or decrease in people's support needs.

Once fully operational, the new electronic care planning system would be able to be accessed by all staff, as well as relevant people with appropriate clearance from outside the service, such as social workers. This would allow for staff to share and receive information about people's support more immediately and transparently. This meant staff could be able offer a faster and more consistent response when implementing any necessary actions or updates to people's support plans, in the event of any changes to their needs.

Since the last inspection, the service had reviewed how people were supported with activities. They had recently delegated a member of staff as a 'meaningful activities lead'. They reviewed people's goals and outcomes, assessed via the 'Recovery Star' assessment process and carried out an activities assessment of people's personal and social interests. This information was shared with staff and the activities co-ordinator and used to create weekly individual and group activity schedules.

The new activity support processes were still being embedded and documentation regarding activities was not always consistently recorded at the time of the inspection. However, we saw examples of how the new approach was helping ensure people had support to follow their interests and take part in appropriate and relevant activities.

For example, one person had been supported to access a programme of learning about their recognised medical condition at a local college. This had helped educate them so they were able to better understand their medical diagnosis, how it could affect them and what they could do to help manage this. Group activities were planned to consider the mental health support needs of people. There were regular 'park walks with mindfulness' sessions in the local community. Mindfulness is a psychological process of bringing people's attention to the present moment to promote mental wellbeing.

Other group activities such as meditation, yoga and stretching classes were offered and these were also designed to promote and enhance people's emotional and physical well-being. People's individual and group activity schedules were designed to be flexible around people's individual needs. This included accommodating people's protected characteristics when they displayed a preference for an activity. For example, the stretching class incorporated chair based exercise routines for people with disabilities.

People had 1:1 time allocated to them on a flexible basis so they could follow their interests and take part in meaningful activities while ensuring their needs were met. For example, a person was a keen fan of exercise

but a condition of their support was that they could not go out alone and had restrictions on where they went outside of the service. Staff arranged for them to have specific 1:1 support within a certain geographical area to allow them to attend a local sports centre.

People had support to develop and maintain relationships with people in the service and in the wider community. People's personal visitors were welcome. Some people said they enjoyed the company at the service and there was a good social atmosphere. Other people preferred not to socialise with others at the service but said staff would always come and spend time with them so they were not on their own.

Several people had moved to the service from other parts of the country. A visiting professional told us staff were very good at supporting people to maintain community links and relationships with the areas they had originally come from. This helped people to avoid becoming socially isolated and maintain their mental well-being.

People told us they knew how to raise a complaint and were confident to do so if necessary. People said thought they would be listened to and respected if they had to do this. There was a complaints policy and information about raising concerns displayed on communal noticeboards in the service. The manager looked to resolve all complaints as quickly as possible and any formal complaints were investigated and responded to in an empathetic and timely manner.

The service supported people to have support with planning, managing and making decisions about their end of life care. There was an End of Life Care and Advanced Care plan policy in place that outlined how to ensure people were supported when approaching their end of life with respect and empathy. This included respecting any religious or spiritual wishes and offering people emotional reassurance.

The end of life care policies also included necessary measures to take to provide people with the correct palliative care support, resources and equipment. This helped to make sure people would have as comfortable and pain free a death as possible.

Is the service well-led?

Our findings

People told us they thought the manager and staff were friendly and approachable and that this was a well-led service. One person said, "The staff and manager are very good".

We found the service was committed to delivering person centred care to achieve good outcomes for people. The provider and manager were embedding new quality assurance systems and processes to ensure the service could consistently deliver high quality support in a timely manner.

The service was rated inadequate in the Well-Led domain at the last inspection. Systems or processes to assess, monitor and improve the quality and safety of the services provided were not operating effectively. Records relating to the management of the service were not being maintained. These failures had put people's safety at risk. At this inspection we looked to see if the provider had acted to address these issues.

At the last inspection we found the service's quality assurance systems had failed to identify risks to people's safety, where provision care was inappropriate and that some records did not contain enough detail to support a review of people's needs. The lack of awareness of these issues meant the provider had not acted to do all that was possible to reduce these risks and provide appropriate care to people. We also found that where risks had been identified, the provider had failed to do act which left people at significant risk of avoidable harm.

In response to these findings, the provider had implemented new quality assurance systems. The manager carried out daily, weekly and monthly reviews using information from a variety of internal data sources to audit all areas of the safety and quality of the service. The audit structure and formats had been revised to be more comprehensive and to take place more frequently. This helped to ensure there was less chance that risks or issues might not be identified.

The provider had added more consistent and structured governance system to oversee the effectiveness of their quality assurance system. An on-going development and service improvement plan had been created. Agreed actions on these plans had a set date for review. This helped prioritise actions, so urgent issues were not left outstanding for unacceptable periods of time.

An area manager had been assigned to visit two or three times a week and carry out a formal monthly review the progress of the actions on the development plan. This provided the manager with further support to make sure actions to address quality and safety issues were effective and could be achieved in a timely manner.

The new quality assurance systems and governance framework had been fully operational for less than six months at the time of this inspection. The system had been effective in helping to drive and achieve improvements in many areas identified as an urgent priority following the last inspection. These areas included; risks to people from insufficient fire safety measures at the premises, risks of pressure damage and injury to people from incorrectly fitted lap belts, poorly maintained premises and equipment and provision

of appropriate care to people with their consent.

However, it was not always evident that issues had been identified or if action had always been taken in a timely manner to address known quality and safety risks. For example, outstanding issues and risks related to infection control and management of medicines that were found during this inspection.

There had been a delay before the manager had become aware of issues relating to unaccounted for medicines. Although action was taken once this had been brought to their attention, for several months it had not been known if people had received their medicines as intended. Infection control issues had been identified and actions considered and put in place to address this, but these had not been effective. In the interim, service performance in this area had not been re-evaluated to consider what else could be done and more effective actions taken to improve this. This meant the service had not been consistently clean and hygienic for a protracted period.

Due to a change in management since the last inspection, there was not currently a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager of the service was fulfilling the role and responsibilities of the registered manager until they were formally registered. This ensured that all legal requirements of the service, including submission of CQC statutory notifications and sharing of required information with other agencies related to the service, were met as expected.

The manager promoted and supported open and transparent partnership working with agencies such as the local authority care management and safeguarding teams, clinical commissioners and multi-disciplinary health and social care professionals. This allowed sharing of information and advice to help the service to provide good quality support to people. A visiting social care professional told us the service worked well with other agencies saying, "Their communication is good and they have a valid interest in supporting people well".

People and staff told us that the recent change in management had been positive. One person said, "I like the manager they are nice". Other people told us they felt they knew the manager and could talk to them. The manager said they wanted to create a supportive and open culture by being visible and building up a good rapport with people and staff. They said, "I am direct and I have an open-door policy. I like to lead from the front and I would not ask staff to do anything that I wouldn't do myself". Staff said this was leadership style was effective. One staff member said, "I feel supported and I can discuss with the manager when I am finding work difficult".

The service had an Equality and Diversity in place to protect staff's equality rights. The manager told us they had a diverse staff team and promoted inclusion and respect of staff differences. For example, adjustments were made to support staff with dyslexia and English lessons had been provided for staff who did not speak this as their first language. Staff told us the culture at the service was fair and transparent. One staff member said, "We have a good team and we get on well. I can be open". Another staff member said they felt they were valued.

Staff well-being was also protected and respected. There was a stress management policy in place that outlined a commitment to helping staff to positively manage stress caused by factors inside and outside of

work. The manager could offer additional supervisory support and work place adjustments to staff who may be experiencing well-being issues. Alternatively, the service could refer staff to independent occupational health services and would support them with any further recommendations relating to their physical and mental health care.

The service had a clear vision of enabling people to achieve their preferred outcomes and goals in life. The manager told us to achieve this vision, staff were expected to display values that were conducive to building holistic therapeutic relationships with people. These values included having a person-centred approach and respecting people's dignity and upholding the right for people to be treated equally.

The manager used supervisions, appraisals and disciplinary processes to support staff to display the expected values of the service and understand the specific accountabilities and responsibilities of their roles. Staff said these processes were effective and constructive. One staff member said, "I came here from a health care background and was used to supporting people from this perspective. I initially struggled with the transition, but my induction and supervision helped me to understand about how to consider people's social needs as well. This helped me to build better relationships with people".

Staff involvement in helping to develop the service was encouraged. The manager discussed issues and asked for ideas about making improvements in supervisions and held regular team meetings. A staff member told us, "The team feels confident to offer suggestions". Another staff member said, "Whenever changes are made these are discussed and agreed first, if there are any disagreements then this is always sorted out".

People were encouraged to be share their views on what was and was not working at the service and what could be improved. People said they had received a survey asking about the quality of the service. The manager told us that they planned to invite a sample of people living at the service to carry out a monthly 'environment review' and also send out more frequent quality surveys to people and relatives. This would enable the service to receive more consistent and regular feedback about how they could make the people's support better.