Mrs L Whitehouse

St Brigas Residential Home For Adults with Learning Dissabilities

Inspection report

St Brigas
2-3 Jesmond Road
Clevedon
Somerset
BS21 7SA

Tel: 01275870653
Website: www.stbrigas.co.uk

Date of inspection visit:
12 October 2016
14 October 2016

Date of publication:
24 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 12 and 14 October 2016.

St Brigas Residential Home for Adults with Learning Dissabilities provides accommodation and personal care for up to 17 people with learning difficulties, autism spectrum disorders, mental health issues and other complex diagnosis. Most people at the home were unable to communicate verbally and some found it difficult to interact with visitors. During the inspection there were 15 people living at the home. The accommodation is arranged over three floors with some office space at the top of the house. There is an area set up as a day centre on the ground floor which includes a kitchen, art room and music room. In the residential part of the ground floor there are a number of communal spaces including a lounge, further kitchen, wet room and dining room.

At the last inspection, in July 2015, we found breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not recording all recruitment checks or accidents and incidents. Some people did not have risk assessments to reduce the risk of harm. The provider was not following the principles of the Mental Capacity Act 2005 when people lacked capacity to make decisions. Staff were not using personal protective equipment when handling soiled laundry and there were no systems to keep this separate. We found the home was not well led because the auditing systems which were in place had not identified all the shortfalls found. Since the last inspection, the provider shared changes they had made in the home. They told us all concerns had been rectified. Although there had been some improvements, we found there were still concerns.

The registered manager was also the provider and they were only present on the first day of inspection. A registered manager is a person who has been registered with the Care Quality Commission to manage the service. They are a 'registered person'. 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 registered manager was supported by a deputy manager and team leaders.

People told us they felt safe but we found there were risks to their safety. There were concerns about the medicine management in the home. Medicines taken 'as required' rather than regularly did not have written protocols for staff to follow and there were medicine errors which had not been identified by the provider's audits.

Where people lacked capacity to make decisions the principals of the Mental Capacity Act 2005 were not always followed. This meant some people were at risk of having their human rights breached.

There were quality assurance systems in place, but these had not picked up all concerns found on this inspection.

Staff and relatives told us there were enough staff to support people. There was a recruitment process in

place but the provider had missed some checks which increased the risk of harm to people. Staff told us they had an induction and had received a lot of training. There was good understanding of how to support people.

Staff knew how to protect people from avoidable harm or abuse and had received training in safeguarding. They told us they would be confident reporting any concerns to the management and staff knew who to contact externally. The provider understood when they were responsible for informing the local authority and CQC about safeguarding.

Staff and the provider had understanding about Deprivation of Liberty Safeguards and what process to follow.

Staff supported people to see a wide range of health and social care professionals to help with their care. Staff supported and respected the choices made by people. Staff knew how to respect people with different religious needs.

People had a choice of meals, snacks and drinks, which they showed us they enjoyed. When people expressed they wanted something different it was provided. People were involved in preparing some of their food. When people required special diets these were met. Staff encouraged people to provide feedback on the food even if they were unable to verbally communicate.

People and their relatives thought the staff were kind and caring and we observed positive interactions. The privacy and dignity of people was respected and people were encouraged to make choices throughout their day.

There were care plans for all individuals including their likes and dislikes. These plans made people central to their care and any decisions made. The needs of people were reflected within their plans. Staff had excellent knowledge about people's care needs.

People and relatives knew how to complain or had the information available if required. There had been no formal complaints since the last inspection. The registered manager and deputy manager demonstrated a good understanding of how to respond to complaints.

The registered manager had a clear vision for the home and had systems in place to communicate this. Relatives and staff were aware of these visions.

We have made a recommendation about staff recruitment.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

People were not always supported by staff who had the correct recruitment checks to keep them safe.

People's medicine was not always managed safely.

People had risk assessments which were required to help keep themselves and others safe.

People were supported by enough staff who knew how to keep them safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People lacking capacity to make decisions their human rights were not always protected.

People who were at risk of having their liberty deprived had the correct procedures followed.

People were supported by staff who had received training and supervision.

People had their nutritional needs met including those who required a special diet.

People had access to other health and social care professionals and staff knew when to contact them for advice.

Is the service caring?

Good

The service was caring.

People and relatives told us they were well looked after and we saw the staff were caring.

People were involved in making choices about their care.

People's privacy and dignity was respected and there were a staff member to promote this.

People's religious needs had been considered.

Is the service responsive?

Good

The service was responsive

People had care plans that were personal to their needs and wishes. The care plans were responsive to changes.

People had access to a range of activities which were personalised to meet their likes and dislikes.

People and relatives knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had audits, but they had not identified all shortfalls or demonstrated the time frames actions would be completed in.

People and relatives had not always been notified about CQC ratings inspections by the provider's website or entrance to the home.

People were living in a home where the provider had a clear vision which was communicated to staff and relatives.

People benefitted from the provider building good links with the community.

St Brigas Residential Home For Adults with Learning Dissabilities

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 14 October 2016 and was unannounced. It was carried out by one 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 care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

During our inspection we spoke with two people about their views on the quality of the care and support being provided. We also had informal conversations and completed observations with other people throughout the day who were often unable to verbally communicate with us. We spoke with six members of staff including the registered manager, the deputy manager, care workers and cleaning staff. Following the inspection we spoke with three relatives on the telephone because during our inspection most people were unable to verbally communicate with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care records. We observed care and support in communal areas. We looked at

four staff files, previous inspection reports, staff rotas, quality assurance audits, the compliments and complaints systems, staff and resident meeting minutes, medication files, environmental files, handover forms, the communication book and a selection of the provider's policies.

Following the inspection we asked the deputy manager to send us further information including the training records and information in relation to concerns found on the inspection. All these were sent within the time frame requested.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection, in July 2015, the service was not consistently safe. There was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because concerns were found in relation to records for staff recruitment, incidents and accidents and risks relating to people. Following the July 2015 inspection, the provider told us they had made improvements in all areas. At this inspection, we found the provider had taken some action to address our concerns. For example, incidents and accidents were now recorded in a central location. These had been written for when people had hurt themselves. The registered manager had created a system to analyse these incidents and accidents. Any actions for staff to reduce the risk of harm to the person had been recorded.

At this inspection we saw people had clear guidelines to go with their risk assessments and staff were aware of how to keep people safe. For example, we were walking with a member of staff past a room and they immediately went to a person trying to get up. This person had previously been identified at risk of falling. The provider had held an emergency staff meeting in July 2016 to share new guidelines for this person. The member of staff told us they were aware of these guidelines and the action needed to make sure the person was safe. This meant the provider was identifying risks to people and recording the measures require to keep them safe.

Care plans contained risks assessments which outlined measures in place to enable people to take part in activities with minimum risk to themselves and others. For example, one person had a risk assessment for summer time. This gave guidance about keeping the person hydrated and preventing sunburn. Other people had risk assessments for choking, slips, trips and falls and access to the community. Staff we spoke with were familiar with the risk assessments and knew how to reduce the risks of harm.

The provider had requested new Disclosure and Barring Service (DBS) checks for all staff to make sure they were safe to work with vulnerable adults. However, we still found concerns with the recruitment process. The provider did not always have a complete record of staff's previous employment. For example, two staff members had gaps in their employment history with no information to show the provider had found out why. We spoke with the deputy manager who had no knowledge of the gaps.

The provider was not following their own recruitment procedures. For example, One member of staff only had one reference. Their recruitment policy and PIR stated each member of staff should have two. The deputy manager was going to follow this up with the member of staff and the registered manager. This meant people were at risk of harm from staff working with them whose conduct in employment had not been fully checked.

We recommend that the service consider current guidance on recruitment of staff and take action to update their practice accordingly.

At the last inspection, in July 2015, the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Concerns were found with poor use of personal protective

equipment, such as aprons and gloves, when staff were handling soiled laundry and inappropriate infection control. Infection control is when policies and procedures are in place to reduce the risk of infections spreading. Following the July 2015 inspection, the provider told us and they had made improvements in all areas of infection control. At this inspection we found there had been improvement because all staff, when required, were seen handling laundry using aprons and gloves. There were visual reminders for staff around the home to remind them to follow the procedures. New laundry trolleys were in place and staff were keeping soiled laundry separate. The registered manager told us there was a special hot tap designed to pre-wash the laundry before putting it in a separate wash; this would ensure. All staff were aware of the new procedures. This meant the risk of infections spreading was reduced when staff handled soiled laundry.

Medicines were not always managed safely. There were suitable secure storage facilities for medicines. The previous PIR told us the provider planned to change their medicine management system and pharmacist to improve the safety to people; both these actions had been completed. The provider now used a medicine administration system with printed medication administration records (MAR). Staff told us they preferred this system because less could go wrong. We saw medication administration records. We noted most medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail for these medicines and enabled the staff to know what medicines were on the premises. We checked records against stocks held and found most of them to be correct.

However, when people were absent from the service the systems in place did not record quantities of medicines taken and returned to the home. This meant there was a risk people's medicine could go missing. For example, one person had visited their relatives but the amount of tablets in stock was not correct. The medicines had been signed out and back in with no record some had been administered. We spoke with staff and relatives to confirm some of the medicines had been taken whilst the person was at home. The deputy manager said they would put a new system in place to record medicines leaving the premises more accurately. On the first day of inspection we found one 'as required' medicine had no medicine administration record (MAR). By having no record it meant the medicine could be misplaced without anyone knowing. We spoke with the deputy manager who explained the MAR had been written but had gone missing. By the second day of inspection there was a record in place.

No 'as required' medicines had guidelines to inform staff when, why and how much should be administered. These were important because most people lacked the ability to communicate this information to staff. The registered manager explained all staff were aware how to administer the medicine due to being familiar with people's needs. They explained no agency staff were used. However, one person had instructions on their medicine to take two tablets, two hours before travel, then one or two when they were leaving. It was not clear whether one or two tablets should be given and there were no guidelines for staff. The deputy manager told us staff "Just know when and what to administer" but understood why guidelines would prevent confusion. This meant people were at risk of incorrectly receiving their 'as required' medicine which could cause them unnecessary anxiety or pain.

There had been improvements in the way the provider managed risks associated with fire. The provider had created grab bags for each floor of the home these contained essential information required for evacuations in the event of a fire. We saw objects propping two communal fire doors open. The deputy manager said, "It was standard to leave the two doors open". They would find out if there was any way of using door closures linked to the fire alarm system. Some people were reluctant to evacuate the building when the fire alarm sounded. The deputy manager explained one person was more likely to leave their room once the home had been evacuated but refused if prompted earlier. Following the inspection we shared our concerns with the fire service.

Two people able to communicate with us said they felt safe. Relatives all agreed their family members were safe. When we spoke with relatives they said, "The home is very safe. Never have any worries", "Yes, they are very safe" and "They [meaning the staff] do everything they can to keep [my family member] safe".

Staff told us, and records seen confirmed, all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. One member of staff was able to tell us it was about making sure all the people's needs were met as well as keeping them safe from harm. All were confident any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. Relatives said, "Yes, there are enough staff" and "Whenever we visit there are enough staff". We saw when people required support it was provided. During a meal there were periods of time when some people did not have interactions from staff. A member of staff told us this was because some people did not appreciate communication whilst they were eating. They explained this was due to previous experiences or they became anxious. This meant people were supported by staff who understood their needs and wishes to keep them safe from distress. Some people had individual support from a member of staff when they accessed the community. This was in line with the person's risk assessment.

Many of the staff had worked at the service for a long time and knew people well. Staff told us due the stable staff team meant people did not get as anxious. Some staff told us they had worked for the home for 12, 18 and 19 years. One of the members of cleaning staff told us they had left to work somewhere else. But they missed working at the home and the people so much they had come back.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection, in July 2015, there was a breach in Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because concerns were found when people lacked capacity to make specific decisions. The principles of the Mental Capacity Act 2005 were not always being followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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. Following the last inspection the provider had told us all concerns in relation to the MCA had been resolved.

At this inspection we found there had been some improvements. For example, the principles of the MCA were followed for people lacking capacity to make decisions relating to their medicines or meals where there was a risk of them choking. There were other best interest decisions for medical appointments, financial affairs and personal care. Staff had been attending training on the MCA including on the first day of inspection. They told us what they had learnt and how they were going to put it into practice. Staff demonstrated a good understanding of working within the principals of the MCA when a person lacks capacity.

However, there were still occasions when decisions had been made for people who lacked capacity without following the principals of the MCA. For example, one person had a risk assessment for evacuation in the event of a fire which said, "If [name of person] stays in his room staff are to shut the door and alert the fire brigade when they arrive". The risk assessment continued to say "These identified measures have been decided that it is in [the person's name] best interest". We spoke with the deputy manager who confirmed no capacity assessment or best interest decision had been documented. Other people in the home had similar decisions made. Again, the deputy manager confirmed the principles of the MCA had not been documented. Two people's relatives told us they could not remember this being discussed with them. This meant people's rights were not being fully protected where they lacked capacity to make decisions for themselves. Following the inspection the provider sent us completed MCA assessments and best interest decisions for each person living at the home.

Two people had a medical condition which required them to have special equipment to monitor them at night. By monitoring them it would alert staff to any deterioration in their condition. One person lacked capacity to understand the equipment was in place and one person had fluctuating capacity. Fluctuating capacity is when a person sometimes understands what the decision is and at other times they do not. Their care plans contained no information to demonstrate the principles of the MCA had been followed about the decision to use the equipment. We spoke with the deputy manager who confirmed there had been no capacity assessments or best interest decisions recorded. This meant people were at risk of being closely monitored without their consent and the home was not following the principals of the MCA. During the inspection one person's capacity assessment was completed and another person's was being planned.

This is a breach in Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider had correctly applied for DoLS when it was required. For example, to keep people safe from accessing the community alone there were locked gates at the entrance to the house. If people had capacity they had signed a consent form for these gates to be in place. One person had an authorised DoLS with no conditions. Another person had an expired DoLS which was going through reassessment. Other people had applications completed. This meant the provider was protecting people's human rights by correctly using the DoLS process.

People received effective care and support from staff who had the skills and knowledge to meet their needs. Staff told us they received lots of training. One member of staff said, "I have had epilepsy, autism, and medication training this year. I am due to do health and safety training". They explained the registered manager was completing competency observations to safely administer medicines. By carrying out observations the registered manager was ensuring staff were administering it safely. Other members of staff said they were "Well trained" and "If there is training I want I can have it". During the inspection we saw members of staff participating in additional health and social care training such as level two diplomas in health and social care. Records showed most staff training was up to date. Moving and handling training was not updated in line with their own procedures. The registered manager and deputy manager told us they had no one living at the home who required specific equipment to aid them with moving. They were aware some people in the home were becoming less mobile; they were looking at what the most appropriate moving and handling training would be for staff. This meant the provider was ensuring staff would receive training to meet people's changing needs.

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. All staff had recently participated in refresher courses which reflected the Care Certificate. The Care Certificate is a set of standards social care and health workers follow and is the new minimum standards which should be covered as part of induction training. The registered manager felt it was important all staff regularly had refreshers to maintain the high care standards.

All staff we spoke with and records confirmed staff had received an induction and regular supervisions. Supervisions were an opportunity for staff to discuss their practice and training needs. It was an opportunity to address any concerns with members of staff. One member of staff said, "I have supervisions once a month". Another member of staff explained they were responsible for leading some supervisions and appraisals. They told us about the value of these meetings because job roles could be discussed. The staff member said appraisals provided an opportunity to give "Good feedback. This helped self-esteem and staff feeling more valued". All staff who had worked at the home for over a year had received annual appraisals. This meant the provider was supporting its staff to provide high quality care for people.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Sometimes people helped to prepare their lunch. Everyone appeared to be enjoying the food during the inspection. Some even asked for second helpings and this was provided. One person had a poster in their bedroom promoting healthy eating. There were pictures of food they liked and a note saying "I must continue to lose weight to aid my fitness". The cook was aware of everyone's special diets and preferences. They told us "[Person's name] does not like slices of meat so they have sausages instead of meat for Sunday roast". They told us people unable to verbally communicate preferences would push food away if it was not

wanted. If this happened they would make them something else.

At lunch time we saw people were able to choose where they ate their meal. Most people chose to sit in the same place. One person had struggled to sit with some people; staff were aware of this and suggested a different place for them to eat. The person had the capacity to agree to this change. During the inspection this person was supported and enjoyed their dinner. If a person wanted to eat in their bedroom they were assisted to. The registered manager told us one person was becoming distressed during their evening meals. Staff had identified this was because they wanted to go to bed earlier. On the first day of inspection they adjusted this person's routine to support them to have dinner earlier so they could go to bed earlier. On the second day the deputy manager told us this new routine had been a success. This meant staff helped people with their preferences around meal times.

The staff arranged for people to see health care professionals according to their individual needs. Care plans showed us people had appointments with dentists, opticians, GPs and occupational therapists. During the inspection staff had identified one person was not well. They explained they knew this through the person's body language, behaviour and other non-verbal communication. All this information was in line with the person's care plan. As a result, the staff had arranged for the GP to visit who prescribed some medicine. Relatives told us "We take [name of family member] to hospital but if we couldn't we knew they [meaning the staff] would". Another relative explained their family member had seen doctors and psychologists because of their anxiety. The staff had worked on the strategies suggested. The relative said, "They [meaning the staff] have taught him to put his hand on his heart and recognise it is beating faster". They explained because of this and a specific sign the person is now able to manage their own anxiety.

The provider had worked hard to make sure people could help decorate parts of the home so it is more personalised. One person was struggling with other people walking in their room and touching their personal belongings. It was agreed and risk assessed a colourful gate would be put across the person's bedroom door to reduce this happening. This meant the person could have their door open and be monitored for their health condition. Another person, with capacity, saw this happened and wanted a gate for their bedroom, we saw this had been arranged. We saw people designed their own bedrooms, chose their own furniture and colour schemes because each bedroom was personalised. Relatives and staff told us about the process of involving people in the decisions. Two people were unable to visit the shops. The staff used catalogues and the internet so these people could choose what they wanted. We saw each bedroom was different and personalised.

Good

Is the service caring?

Our findings

We saw people were supported by kind and caring staff and their relatives confirmed this. For example, one person became anxious because they thought they were going to be late. A member of staff recognised this and said, "I can take you down there in my car" which calmed them down. Relatives said, "[Name of person] is well cared for"; "Excellent care" and "Always give them great respect". During the inspection staff would check people were alright even if they were just walking past them.

People's privacy was respected and all personal care was provided in private. Personal care is when staff provide support with intimate care such as washing and dressing. Relatives told us "They [meaning the staff] respect privacy" and "They [meaning the staff] respect they are adults and their privacy". Staff told us sometimes people did not understand it was important to be dressed in communal spaces; they were always redirected to their bedrooms and supported to put on clothes. Relatives confirmed this was the case. Staff knew they should shut the door and close curtains when supporting people with their personal care. Staff said, "We use privacy curtains and doors for people having baths" and "We always have doors closed". This meant they understood to protect people's dignity it was important to deliver personal care in private. The provider had designated the deputy manager as the dignity champion. Dignity champions challenge poor care, act as a good role model and educate those working around them. This was in line with their PIR. During staff meetings the topic was discussed and promoted led by the deputy manager. There was a poster at the entrance of the home to share this information with visitors.

Staff told us people were able to have visitors at any time. One relative said, "I can just walk in at any time". Other relatives agreed with this. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. One relative explained the staff always leave them with their family member whilst they visit. The deputy manager and registered manager told us visitors were always welcome in the home. Every visitor was asked to sign the visitor's book when they arrived. If visitors not recognised by staff their identity was checked. For example, a delivery driver arrived with some post during the inspection. The deputy manager checked who they were when they arrived at the front door. This meant people were able to have visitors but were kept safe by staff.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their bedrooms. One person, who was unable to communicate verbally, became unsettled in the afternoon; members of staff spent time trying to find out what they wanted and where they wanted to be. We saw another person wanted their nails painted. The person was unable to verbally communicate, but a staff member spent time finding out what colour they wanted. One relative said, "[Name of person] makes their own choices". They explained staff have helped them understand their family member is now an adult and their choices must be respected. For example, if they chose not to go out in the minibus it should be respected.

There were ways for people to express their views about their care. We saw staff using signs with people including ones they had made up and preferred to use. Other people were shown objects and pictures or pointed at what they wanted. One member of staff told us lots of photographs were taken when out in the

community. This was so the pictures could be discussed with people and used at a later date when members of staff spent time trying to work out what people were trying to communicate. By doing this it showed staff understood the needs of people by giving the time they needed to make themselves understood.

Most people had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. One relative said, "Over the years we have had reviews" whilst another told us they were invited by the provider to reviews of their family members care. One relative told us they would like more frequent reviews for their family member. They explained they had been consulted even if there had not been more formal reviews. The deputy manager told us they always try and involve people in their reviews even if the person could not attend the full meeting. The deputy manager told us reviews were held at the home. Sometimes they were organised by the person's social worker and other times by the staff. The reviews were an opportunity for people and their relatives to input about the care they received and whether they were happy. It also provided a place to discuss any changes or important decisions which needed to be made.

Staff were aware of issues of confidentiality and did not speak about people in front of others. When they discussed people's care needs with us they did so in a respectful and compassionate way. One person joined a discussion we had with a member of staff. The member of staff ensured the person was involved in the discussion and avoided talking about other people until they had left. The office door containing information about people was always locked when no staff were present. By doing this they were protecting private information from being seen by unauthorised parties.

People's religious needs were respected. One person wanted to go to church at Christmas time to listen to the carol singing. Staff told us they always made sure the person went to church at Christmas. A relative told us their family member was a member of the Church of England. They continued to explain the home always celebrated Christmas and Easter to respect the religious celebrations. This meant people's religious needs were being met.

No people in the home had end of life plans which are important to ensure people's wishes are respected. The deputy manager explained because the people were young it had not been considered. They explained on one occasion when a person had a health scare plans had started to be implemented. However, these were not completed as it turned out there was no need for them. The deputy manager understood how these plans could be important because no one could predict the future. For example, if someone was involved in an accident they were not clear what their wishes would be. The deputy manager said they would make an action to discuss end of life plans with people and their families.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. People were able to make choices about all aspects of their day to day lives. Staff understood and knew the people they supported in depth. For example, one member of staff told us about the specific signs a person used for Halloween. We saw this person was able to sign to staff for the remote control for the television and staff understood. Other people pointed or showed staff where they wanted to go or what they wanted to do. By knowing people well staff were able to provide the care and support they required.

All care plans had clear guidelines for staff to follow. They promoted independence and choice. For example, one care plan said "I like a drink with my pills, usually juice but I may change my mind so please offer me choice". By having detailed plans staff could refer to them if they were not sure about how to support a person.

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. Each care plan had a visual section which was accessible to the person. Alongside this was a more detailed section for staff. People had been involved in helping to create the visual care plans. These covered their likes and dislikes, help they needed from staff and information about where they live. For example, one person's care plan said, "I must have shoe laces tied for me as I am at risk from tripping. Some of the things they liked included a glass of sherry and playing with toys. When there had been input from other health and social care professionals these had been added to the care plans.

The staff responded to changes in people's needs. When people had a sudden change in support needs emergency staff meetings were held to discuss new ways of supporting the person. By doing this the management were making sure all staff had an opportunity to learn about the changes. We saw the registered manager accessing information about people where documents about them had been archived. They recognised historical incidents which had previously been managed using support from other health and social care professionals. The registered manager told us strategies of delivering the care to the person which worked before could be used by staff now. This meant the management were proactive in making sure people's care and support needs were met when changes occurred.

People were able to take part in a range of activities according to their interests. Each person had a pictorial timetable in their bedroom. This was so they knew what was happening during the week. One relative explained if their family member showed staff they were not enjoying something it was changed. For example, the person used to go to hydrotherapy and a golf range but they no longer attend them. Another relative told us due to the person's health condition they struggle to access parts of the community by vehicle. They told us staff have found numerous activities within walking distance of the service.

During the inspection we saw a number of activities people were participating in. For example, on the second day of the inspection, people were involved in a cooking session where they prepared pizzas for their lunch. We were told by a member of staff this happened every Friday instead of the cook preparing lunch.

The provider had created a day centre as part of the service where most people went during the day. Every Wednesday and Friday there were music and movement sessions run by a therapist. The deputy manager told us one person has an individual music and movement session with the therapist every month.

People had regular access to the community. For example, one person enjoyed going to the cinema whilst another regularly went to the shops to choose a cake. A member of staff told us about another person who accessed a different day centre. One person had chosen to stay in their bedroom watching television rather than attending the day centre. The registered manager told us about the new minibus they had purchased to allow people to access the community and attend activities. They believed everyone had a right to be in the community and they had built links with local shops. This meant if people got lost in the community they were able to find out if they had been seen in their favourite shop. It was a system to help protect people whilst ensuring they had some independence.

People were supported to maintain contact with friends and family. Relatives told us they regularly visited or staff helped people to visit them. One relative explained their family member was unable to visit them due to anxiety caused by their health condition. Staff had worked hard to find a way to use a small amount of medicine prescribed by a doctor. This person was now able to travel home in the car. Another person had moved in from a different service which had closed. Some of their friends now lived at different homes in the area. Staff regularly supported the person to be in contact with their friends. For example, one staff member had a conversation with the person about going on a dog walk with a friend and the person responded about how they had enjoyed it. By encouraging friendships with peers it was positive for a person's well-being.

The registered manager sought people's feedback and took action to address issues raised. There had been recent questionnaires sent to relatives and health care professionals. The questionnaires for relatives used to require them to tick the box which matched their opinion. The registered manager told us relatives were not keen on this system as it did not allow them to say what they think. In response the registered manager had sought feedback from relatives by asking them to write what they felt and if there were any improvements which could be made. If relatives were unable to write their opinions down, the registered manager organised for a member of staff to phone them and transcribe what they were saying. By listening to relatives' feedback the registered manager was able to make changes and follow-up suggestions. For example, some people were not happy using their en-suite bathroom so a new wet room on the ground floor had been created.

There were meetings for people which gave them opportunities to communicate how the service was run. During the meetings topics were discussed such as days out, activities and meals. People were encouraged to add their own topics to the agenda. For example, one person enjoyed going horse riding so this was added. Even if people could not communicate verbally their views were captured. For example, when cooking was talked about the minutes said, "[Name of person] got excited to indicate enjoyment". Another person was asked about a specific activity they attended and the minutes said, "[Name of person] was asked about [the activity name] he smiled and clapped". This meant people's views were valued about the care and support they received.

The provider collected positive feedback from relatives and visitors to the home. For example, one relative said, "We are very happy with the care you give [name of person]. We know she is very happy living at St. Brigas and is constantly becoming more independent". Another relative said, "We are very pleased to see what an interesting and enjoyable programme of activities you have". Some visitors said, "I have been so impressed by the standards of care and the huge efforts made to make it a safe home for everybody there" and "As a professional trainer I was impressed by the quality of their [meaning the staff] questions and their

receptive attitude to taking on new ideas".

Each person had a copy of the complaints policy in their bedroom. This was displayed in a way to support those with communication difficulties by having pictures. Relatives were all aware of the complaints procedure but told us they had never had to complain. One relative said, "I am aware of formal complaints procedure and [name of person] has it in their room". Another relative said, "I do know about formal complaints. Never needed it". The deputy manager told us they had further plans to make complaints even more accessible for some people. They explained some people recognise who to complain to by sight. So they wanted to add photographs to the complaint poster in the person's bedroom. By doing this they were showing people who they could complain to.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in July 2015 there was a breach in regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the quality assurance systems had not identified shortfalls with recruitment procedures, personal protective equipment, the MCA and accidents and incidents.

During the latest inspection we found there had been some improvements. There were now clear records for accidents and incidents. These included management actions in response to mitigate the risks of harm to people. A new laundry system had been developed including the ability to keep soiled items separate. There had been work to remind staff when and where to use personal protective equipment.

There was a system to manage the quality assurance process. This included the registered manager assigning specific audits to members of staff. As they were the provider, this meant they could have more of an overview role. For example, the deputy manager was now responsible for the medicine management in the home. They were able to talk us through all the changes and improvements which had been made. This included a new system and links with a different pharmacist in line with the information in the PIR. Once the audits were completed, the registered manager had an overview of any actions. There were no dates to identify when actions should be completed which meant actions may get forgotten. The registered manager told us this was being developed.

However, concerns were still found with the recruitment system. The registered manager's overview for staff files said, "All up to date, awaiting misplaced certificate". This meant shortfalls found during this inspection had not been identified. No actions had been identified for care plans in June 2016 or October 2016 even though where people lacked capacity some decisions did not follow the principles of the MCA. By not identifying some decisions still required the correct process people's human rights were at risk of being breached. We spoke with the registered manager who explained the quality assurance systems were still being developed. They said now they were in place they would continue improving them so they can identify all shortfalls.

People were not being informed about the most recent inspection from CQC on the provider's website. The provider had failed to include the home's current quality rating on their website in line with the law. Some of the ratings had been included but they were not on the home page of the website. At the entrance to the home the ratings were not being displayed within the law because only the overall rating was displayed. We spoke with the registered manager and another member of staff. Following the inspection the provider responded promptly to address this and displayed the quality rating along with a link to the most recent CQC report on their website. The provider told us they had amended the way the ratings were displayed at the home.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff were positive about the management. During the inspection we saw people smiling and joking with the registered manager and deputy manager. One relative said, "[The deputy manager's name] has always been so helpful and provides advice" and continued to say the management "Always have time for you". When other relatives were asked about the management they told us, "Really helpful and polite" and "Very good". One member of staff said there were "Excellent managers". Whilst others were positive about the support they received from the management.

During the inspection when shortfalls were found prompt action was taken by the management to rectify the situation. For example, relatives were contacted and people spoken with to complete capacity assessments for fire evacuation. Another concern found with medicine recording was resolved by the deputy manager. This meant even when concerns had not been found internally the management demonstrated they wanted to keep people safe or protect their rights.

The registered manager showed us other changes since the inspection in July 2015. For example, they had an office where all confidential documents such as staff files and supervisions could be stored. There were annual plans to ensure staff's training was kept up to date. When the local authority had inspected they recorded any actions identified had been resolved promptly. This meant the provider was responding to concerns so they could keep people safe from harm and receive care in line with their needs.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The registered manager, who was the provider, was supported by a deputy manager. In addition, there were team leaders and senior staff who helped to run shifts and activities during the day. All staff were clear of what their roles and responsibilities were and the support they received. One member of staff said, "We get good feedback. Helped my self-esteem and feel more valued". If they had suggestions the staff felt listened to. For example, a staff member told us they had suggested some changes to people's morning routines; they explained the management had looked into changing them.

The registered manager had a clear vision which was staff were working in the people's home. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Two relatives said, "This is a home from home". Members of staff said, "We are guests in their home" and "It is homely". By having a clear vision all staff were working towards the same goals and providing high quality care for people. One member of staff said, "It is a pleasure to come into work". Whilst another staff member told us the provider was "Prepared to move with the times" meaning it was a forward thinking place to work.

Significant incidents were recorded and where appropriate were reported to the relevant statutory authorities. All incidents had been by recorded by staff and the manager explained that these were regularly reviewed so any trends or concerns could be identified. The provider had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

People had been supported to maintain links with the local community through attending a variety of activities. For example, horse riding and hydrotherapy .The staff led by the registered manager had built links with the local community. For example, they had the contact details of local shops and places people could visit. The registered manager explained they lived in a lovely place which provided a community for the people. We saw people were regularly accessing local amenities. Where people had moved from other homes or areas the staff had worked hard to familiarise them with the area. The registered manager also had developed proactive links with local health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the law, make decisions based on the principles of best interest and obtain consent appropriately. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people received safe and effective high quality care. They had not fully put in place systems to monitor the quality of care people received. Those which were in place had not operated effectively to ensure compliance. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a warning notice