Care Network Solutions Limited

Clarence House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 21 March 2018 and was unannounced. At the last inspection on 8 November 2016 we asked the provider to take action to make improvements around building maintenance and cleanliness. We issued a warning notice in relation to maintenance of the building. Following the last inspection, we asked the registered provider to complete an action plan to show what they would do and by when to improve the key questions safe, and well led to at least good. At this inspection we checked to see whether improvements had been made and found the registered provider was meeting all the regulatory requirements.

Clarence House provides accommodation and personal care for up to 11 people who have a learning disability and complex behavioural or mental health related support needs. It is divided into two units for men and woman. At the time of this inspection there were nine people living there.

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

A registered manager was not in place as they had recently left the service, and applied to de-register as manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The regional operations manager was currently managing the service.

People who used the service told us they felt safe at Clarence House. Building maintenance and cleaning had improved, with some minor issues still apparent, which were dealt with straight away.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse and safe recruitment and selection processes were in place.

Emergency procedures were in place and people knew what to do in the event of a fire. Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Detailed individual behaviour support plans gave staff the direction they needed to provide safe care. Incidents and accidents were analysed to prevent future risks to people.

We saw medicines were administered in a safe way for people. Staff had training in safe administration of medicines although not all staff competency checks on the administration of medicines had been refreshed in the last year. The regional operations manager said these were a priority for completion.

The required number of staff was provided to meet people's assessed needs.

Staff told us they felt supported. Staff had received an induction and role specific training, which ensured they had the knowledge and skills to support the people who lived at the home. The overview of staff training needs was not up to date, although we saw training certificates to show staff had received the relevant training. A new training matrix was forwarded to us following our inspection.

People were supported to eat a balanced diet, and meals were planned around their tastes and preferences.

People were supported to maintain good health and had access to healthcare professionals and services. They were supported and encouraged to have regular health checks and were accompanied by staff to health appointments. The area operations manager promoted partnership working with community professionals and responded positively to their intervention and advice.

The service was adapted to meet people's individual needs, with specialist furniture and fittings.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Positive relationships between staff and people who lived at Clarence House were evident. Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs.

People were involved in arranging their support and staff facilitated this on a daily basis, and they were supported to be as independent as possible throughout their daily lives.

The management team promoted an open and inclusive culture whereby people were encouraged to express their diverse needs and preferences.

Care records contained detailed information about how to support people and included measures to protect them from social isolation. People engaged in social and leisure activities which were person-centred.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were approachable.

The absence of the registered manager had left some recent gaps in governance, which the regional operations manager and senior staff at the service were in the process of addressing, such as medicine's competence assessments and an up to date overview of training.

Improvements had been made to the system of governance and audits within the service and the necessary improvements had been made since our last inspection to meet the regulations.

Feedback from staff was positive about the regional operations manager. The management team were visible in the service and knew people's needs. People who used the service and their representatives were asked for their views about the service and they were acted on.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The building was maintained and managed in a safe way.

Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence and staff had a good understanding of safeguarding people from abuse.

Sufficient staff were deployed to meet people's assessed needs.

Medicines were managed in a safe way for people.

Is the service effective?

Good

The service was effective.

Staff received supervision to support their professional development needs and appraisals were in the process of being updated.

Staff had received specialist training to enable them to provide support to the people who lived at Clarence House.

People were supported to maintain a balanced diet. People had access to external health professionals and the registered manager worked well with other services to improve outcomes.

People's consent to care and treatment was always sought

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy, dignity and diverse needs.

People were supported to make choices and decisions about their daily lives and to maintain and improve their

independence.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed, person-centred and individualised.

People were involved in regular activities inside and outside the home in line with their care plans.

People told us they knew how to complain and that staff were always approachable.

Is the service well-led?

Good

The service was well-led.

The culture was positive, person-centred, open and inclusive.

People told us their concerns were acted on and the registered provider had mechanisms in place to seek feedback from people and their representatives.

The registered provider had an overview of the service and had made improvements to meet the regulations.

Clarence House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 21 March 2018 and was unannounced. The inspection was conducted by two adult social care inspectors 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.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, feedback from the local authority safeguarding team and commissioners. 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 used a number of different methods to help us understand the experiences of people who used the service. We spent time in the lounge area and dining room observing the care and support people received. We spoke with six people who used the service. We spoke with two community professional, two support workers, two senior support workers and the regional operations manager. We looked in the rooms of six people who lived there with permission.

During our inspection we spent time looking at three people's care and support records. We also looked at three records relating to staff supervision, training and recruitment, incident records, maintenance records and a selection of audits.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Clarence House, one person said, "I'm happy here and I feel safe." A second person said, "I feel safe here. If I'm not happy I talk to the staff."

At our last inspection on 8 November 2016 we found the registered provider was not meeting the regulations relating to safety and suitability of premises because cleaning regimes had not always been delivered effectively and maintenance tasks were not always completed in a timely manner by the registered provider. At this inspection we checked and found improvements had been made.

En-suite bathrooms had been refreshed and updated and the building was generally clean, although there was still thick dust in several extractor fans and three of the radiator covers we saw needed to be cleaned and painted. The regional operations manager showed us maintenance tasks had been completed in a timelier manner and cleaning regimes had been improved. This meant maintenance had improved and the building was generally safe, clean and suitable for its intended use.

There were still some minor maintenance issues, for example; the kitchen in one unit was in need of updating, the seal on the fridge was broken and the freezer was in need of defrosting. The regional operations manager told us this fridge freezer was due to be replaced and this was completed immediately following our inspection. The kitchen was due to be updated fully in the near future.

Checks had been completed on fire safety equipment, emergency lights and the fire alarm and action taken to rectify any issues. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing. A series of risk assessments were in place relating to health and safety. This meant people who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Staff we spoke with understood their role in protecting people from abuse and discussed how knowing people well meant they could detect changes. They told us they had received training and showed they understood different types of potential abuse and their role in preventing it. Staff understood how to raise concerns both within their organisation and beyond, should the need arise, to ensure people's rights were protected. We saw information around the home about reporting abuse and whistleblowing, including in an easy read format.

Records showed complex safeguarding incidents had been dealt with appropriately when they arose and measures were put in place to ensure people were kept safe. Safeguarding authorities and the Care Quality Commission (CQC) had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

People who needed one, had an individual personal emergency evacuation plan (PEEP) in their care records and also located in a grab file by the exit door to the home. PEEPs are a record of how each person should be supported if the building needs to be evacuated. Two out of four people in one unit didn't have a PEEP,

however they were independent with evacuating the building. One person who had moved from the home in February 2018 still had a PEEP in the fire file. This was removed straight away. Fire drills had been completed and staff and people were aware of the procedure to follow. This showed the home had plans in place in the event of an emergency situation.

Comprehensive risk assessments were in place in areas such as refusing personal care, smoking, absconding, physical aggression, sharp implements, self-harm, road safety, finances, medication, and additional person specific assessments for specific health conditions and concerns. The risk assessments were up to date and were available to relevant staff so they could support people to stay safe. Staff said they read people's care files and always had pre shift handovers, which had enough information to enable them to care for people safely. Locked sharps were audited daily. This showed the registered provider had an effective system in place to reduce risks to people.

Risk assessments and care plans also contained detailed information about how staff would care for people when they experienced behaviours that may challenge others and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

People and staff we spoke with told us there were usually enough staff on duty. The regional operations manager told us each person who used the service was allocated staff according to their assessed needs and we saw this was reflected in their care records and tallied with the number of staff on duty. We observed there were appropriate staffing levels on the days of our inspection which meant people received sufficient support.

We reviewed recruitment records for three staff who had been recruited since our last inspection. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard practice. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed recruitment systems were robust.

Medicines were managed safely. The service had a system in place to ensure medicines were ordered and supplied in time to be available when the person needed them. We saw the amounts supplied had been recorded on the medication administration records (MAR) and the count of any remaining tablets was brought forward when appropriate. The MAR had been printed by the dispensing pharmacy and included known allergies, the person's name, date of birth and GP details.

Medicines were stored securely in a locked cabinet in the office on each floor. The temperature in the offices had been checked each day to ensure it did not exceed the safe maximum.

We saw mental capacity assessments had been conducted with regard to people's ability to safely administer their own medicines. Where people had capacity they had signed to consent to care staff administering their medicines or to administer their own medicines following a risk assessment.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. This meant people were protected against the risks associated with medicines because the registered provider had appropriate arrangements in place to manage medicines.

The service had a clear policy for the use of 'when required' medicines including the creation of a support

plan detailing why and when the person might need their medication and signs and symptoms specific to the individual. We reviewed the 'as required' medication plan and these were detailed and provided staff with all the information they needed. Staff discussed other ways of helping a person when they became agitated, so offering medication was only used as a last resort.

Medicines were audited monthly by a manager and any issues found had been addressed with staff. The above demonstrated the home had good medicines governance systems in place.

Staff were trained in medicines management and had previously completed medicines competence checks. Not all medicines competency checks had been completed again in the last year. The regional operations manager told us this was due to the registered manager being absent from work and they planned to complete these immediately.

No cleaning staff were employed but staff said they cleaned, or supported people to clean their own bedrooms and staff cleaned communal areas. Staff had access to personal protective equipment (PPE) and discussed when they used gloves and aprons and when they washed their hands to prevent infection. This helped protect people from infections that could affect both staff and people using the service.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed. The incident records we viewed were detailed and contained a debrief for staff on what was learned from the incident. Staff were aware of any escalating concerns and took appropriate action. The incident records we viewed showed the event was subject to senior staff review with any lessons learned translated into care plans.

We saw occasionally a behavioural incident had been recorded in the daily records, and an associated incident form had not been completed. The regional operations manager showed us this had been followed up in staff supervision and staff meetings to ensure all incidents were recorded on incident forms to pass on to senior managers and service commissioners as required.

The registered provider had an overview of incidents and accidents which meant they were keeping an overview of the safety of the service in order to ensure learning from incidents took place.

Good

Is the service effective?

Our findings

People told us they thought staff were able to meet their needs. One person said, "I get the right sort of care." A second person said, "Staff care for me well. I can see the doctor. The staff come to appointments with me." A third person said, "The food is good. We decide what we eat and make our own food during the day."

Physical, mental health and social needs had been assessed and care plans included guidance and information to provide direction for staff and ensure care was provided in line with current good practice guidance. No one who currently used the service required the use of assistive technology.

Staff were provided with training and support to ensure they were able to meet people's needs effectively. New staff completed the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills and knowledge to ensure they provide high quality care and support. Induction records showed staff had received training including fire safety, manual handling, infection prevention and control, emergency procedures, safeguarding and the Mental Capacity Act (MCA). Staff told us they completed a two week induction program including training, going through all the care plans and shadowing a more experienced staff member before they were counted in the staffing numbers. The shadowing focused on getting to know people's individual needs and preferences. This demonstrated new employees were supported in their role.

We looked at the training records for three staff members and saw training also included self-harm and suicide awareness and diabetes awareness. Staff told us and we saw from records they also completed specialist training in preventing and managing behaviour that challenges. The overview of staff training (training matrix) was not up to date; however we saw training certificates for all required training. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

The regional operations manager told us they had been concentrating on implementing the Care Certificate since taking over management of the service and a new staff training matrix was being introduced by the registered provider in the coming weeks. Following our inspection the regional operations manager sent us the new updated training matrix.

Staff we spoke with told us they felt appropriately supported by managers and they said they had regular supervision, an annual appraisal and regular staff meetings. Staff supervisions covered areas of performance and also included the opportunity for staff to raise any concerns or ideas. The regional operations manager showed us they had given out staff appraisal forms for staff to complete, as these were slightly overdue. This showed staff were receiving regular management supervision to monitor their performance and development needs.

One person said, "The food is alright. I decide what I eat. The staff cook the evening meal but if you don't like

it you can have something else." A second person said, "Meals are good. I help them cook. Sometimes I cook my own meals."

Each week a menu was planned for the week ahead in each of the two units and people took it in turns to help staff to make a meal each evening. Meals were planned around the tastes and preferences of people who used the service. People helped themselves to breakfast and lunch with support if required.

We saw the individual dietary requirements of people were catered for and healthy eating was promoted. We saw records of food temperature checks when hot food had been prepared for people to ensure it reached a sufficiently high temperature to prevent contamination. Meals were recorded in people's daily records. This included a record of all food consumed, including where food intake was declined and details of the food eaten. People were weighed monthly to keep an overview of any changes in their weight. This showed the service ensured people's nutritional needs were monitored and action taken if required.

The advice of professionals was included in people's care plans and we saw staff following people's care plans and advice from professionals on the days of our inspection to help people to achieve good outcomes.

People were supported to access external health professionals and we saw this had included GP's, psychiatrists, community nurses, psychologists, chiropodists, dentists and opticians. People also had an up to date health action plan in their care records and a hospital passport. The aim of a hospital passport is to provide hospital staff with the information they need to know about a person with a learning disability when they are admitted to hospital. This showed people received additional support when required for meeting their care and treatment needs.

People's bedrooms were decorated and maintained in line with their personal tastes, with specialist furniture and fittings, which helped to keep people safe.

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

People can only be deprived of their liberty so they can receive care and treatment when this is in 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).

We checked whether the service was working within the principles of the MCA. We asked the regional operations manager about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. Four people were subject to DoLS authorisations with no conditions attached, and three people had been assessed as having the mental capacity to decide to live at the home. One person's DoLS application was awaiting assessment and a further person was subject to different legislation, as they were not yet over the age of eighteen. This meant the human rights of people who used the service were protected and they were not unlawfully deprived of their liberty.

It was clear from observations people's autonomy, choices and human rights were promoted. Staff we spoke with had a good understanding of the MCA and DoLS and they understood the concept of least restrictive methods and how people could often continue to make everyday decisions, even when they

lacked the capacity to make complex decisions.

We found there was evidence of good practice in the assessment of mental capacity and best interest discussions for important decisions, such as coming to live at the service, finance, administration of medicines, medical treatment and any restrictions in place.

One person's records showed they had signed consent to a decision, where a mental capacity assessment had concluded the person lacked capacity to make the decision. The regional operations manager said they would address this inconsistency straight away.

Good

Is the service caring?

Our findings

People who used the service told us they liked the staff and we saw there were warm and positive relationships between them. One person said, "Staff look after me and support me." A second person said, "Staff are kind and treat me with respect." And third person said, "I get on with the staff." A further person said, "The staff are really kind. They are trying to help me out."

A community professional said, "[The person I support] seems happy and the staff are friendly. They are happy to support the independence of residents."

Staff we spoke with enjoyed working at Clarence House and supporting people who used the service. We observed staff speak to people gently or with appropriate humour and banter and they were kind and compassionate. There was a relaxed atmosphere and staff spoke to people with mutual respect. We saw people laughing and smiling with staff.

We found staff had a good knowledge of people's individual needs, their preferences and their personalities and they used this knowledge to engage people in meaningful ways, for example chatting to them about hobbies or activities.

The area operations manager showed us how people were supported emotionally through a recent difficult time of grief and loss and how they remembered their friend who had lived at the home for a number of years.

People's diverse needs were respected and care plans recorded the gender of carer they preferred to support them, as well as their religious, cultural and sexuality related needs. Staff told us they respected people's diverse needs by ensuring they understood the person through their care plan, talking with them and their representatives if appropriate and supporting their cultural and lifestyle choices. This demonstrated the service respected people's individual preferences.

We saw staff at Clarence House were responsive to people's needs, asking them questions about what they wanted to do and planning future activities. Staff were patient with people, and listened to their responses. People were supported to make choices and decisions about their daily lives and care records evidenced this. People told us they had a choice of meals, what time to get up, clothing, activities or when to have a shower. This meant that the choices of people who used the service were respected.

Three people told us they had to be in their bedrooms by 10.30 pm and this was not their choice. We discussed this with the regional operations manager. They told us the impact on other people of some people remaining in communal areas late at night had to be considered in order to promote the rights and wellbeing of all residents. They told us this had been agreed at a residents meeting and people could stay up later in their bedrooms if they wished to, and people confirmed this was the case.

Accessible communication was promoted throughout the service. Staff used speech, gestures, and facial

expressions to support people to make choices according to their communication needs. Information was presented in easy read formats to promote good communication and care plans contained details of how to recognise when a person was unhappy or happy using non-verbal cues.

Advocacy information was on display to promote people's citizenship and human rights and five people had an independent mental capacity advocate or a Care Act advocate. One person had an advocate from children's services. An advocate is a person who is able to speak on a person's behalf, when they may not be able to, or may need assistance in doing so, for themselves.

People told us staff respected and promoted their privacy. One person said, "The privacy is good." A second person said, "Staff always knock on my door and check on me. I get personal space if I want it." We saw staff knocked and asked permission before entering people's rooms and gave people privacy and space when it was safe to do so. People's private information was respected and records were kept securely.

People appeared well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style. People's individual rooms were personalised to their taste with furniture, personal items, photographs and bedding they had chosen.

People told us independence was promoted, one person said, "I went to the [name of shop] and got myself a job." A second person said, "I've been to an open day at college. I'm going to do motor vehicles, construction or landscaping." A third person said, "I'm being supported to move on when I can." People were encouraged to do things for themselves in their daily life, such as washing, cleaning and shopping. We saw people were supported to safely help themselves to a hot drink and meal and maintain their independent living skills. Some people who used the service used the community independently and this control and independence was actively promoted by the service. This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

People told us staff supported them to see their families and friends as often as desired. This meant people were supported to develop positive relationships and to maintain contact with people who were important to them.

Good

Is the service responsive?

Our findings

People told us they were involved in their care plans and we saw they were consulted on every aspect of their support. One person said, "Staff talk to me about the care I need." A second person said, "I've seen my care plan, they talk to me about it."

We found care plans were person-centred and explained how people liked or didn't like to be supported. Entries in the care plans we looked at included, "At present [person] has chosen to be an atheist." This helped care staff to know what was important to the people they supported and helped them take account of this information when delivering their care.

We looked at three people's care plans. Care plans contained detailed information covering areas such as personal choice and self image, spiritual and cultural needs, health, mobility, finance, support managing emotions, likes and dislikes, behavioural, menu options, personal relationships, social activities, personal care, communication, medication and decision-making. They included long term goals the person was working toward. We saw action had been taken to support people in their goals, for example, one person's goal of going out unsupported was being worked towards by going to town with staff and spending a limited amount of time shopping alone in a planned and structured way, with a view to building toward the goal in the longer term.

Care plans contained information in an accessible format with some photographs and symbols to support involvement. The area operations manager told us, and we saw from records, reviews were held and care plans were reviewed and updated regularly or when needs changed. These reviews helped monitor whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage.

Daily records were also kept detailing what activities people had undertaken, support provided, what meals had been eaten, their mood and any incidents.

People told us and we saw from records they had access to a range of activities in line with their tastes and interests. One person said, "I go to computer classes. I go for walks on my own. I go to the disco and play pool every Thursday." A second person said, "I like to help with cleaning but they need better equipment. I play five a side in the community centre. I'm going to buy myself a Freeview box." A third person said, "I go to the library and the park. I like playing mini golf. I go to college to do cooking and DIY. I've been on holiday to [name of resort]." A further person said, "I went to the X Factor tour at Leeds arena. I go bowling to White Rose. I go to college to do cooking, art and woodwork. I'm going on holiday to Bulgaria this year. I've never been there before."

Staff spoke with good insight into people's personal interests and we heard how people were being assisted to lead fulfilling lives and picked the things they wanted to take part in. Records showed each person had an individually planned holiday and one person was being supported to plan their first holiday abroad. One person was unable to go out to the park on the day of our inspection, due to staff availability during the day

of our inspection, but was later engaged in a shopping trip.

Information about the Accessible Information Standard was displayed in the office and the regional operations manager was aware of the requirements of the standard. This requires the service to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. We found detailed information regarding people's communication needs and the communication needs of their relatives, where appropriate, was recorded in care plans, for example information about people's hearing, vision, communication and memory.

People told us they were supported with regular contact with their families, either at in the home or at other locations. Important relationships to people were enabled and encouraged and people were supported to have visitors when it was assessed as safe to do so.

We asked people what they would do if they needed to complain. One person said, "I would complain to the staff, but I haven't needed to." A second person said, "I'd complain to the manager. I once made a complaint and it was listened to." And a third person said, "I'd complain to the manager, I've never had to."

People's views were sought by the former registered manager and the regional operations manager through meetings and one-to one conversations. We saw there was an easy read complaints procedure in people's care files and a complaints box was available in the foyer. Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw complaints or concerns had been recorded when they arose, thoroughly investigated and responded to appropriately. The area operations manager was clear about their responsibilities to respond to and investigate any concerns received and demonstrated learning from complaints was implemented to improve the service.

Some people and their relatives had discussed preferences and choices for their end of life care including in relation to their spiritual and cultural needs. The regional operations manager told us the service had an end of life care pack they were now working through with people and people had discussed their preferences. This meant people's end of life wishes were recorded to provide direction for staff and ensure people's future wishes were respected.

Good

Is the service well-led?

Our findings

People told us the home was well led. One person said, "I've raised things in the past and they were dealt with. We should have meetings once a month but haven't had one lately." A second person said, "Things change after we talk about them at the meetings."

One community professional said, "People's rights are protected by the home. It is a happy place now. The atmosphere has improved in the last six months."

The previous registered manager had left the service in early March 2018 and applied to de-register as manager. They had been absent prior to this for several months and the regional operations manager was currently managing the service three days a week. They were now recruiting for a new manager.

Staff told us they felt supported by the regional operations managers and senior staff, who acted on their concerns. One staff member said "I feel very supported by [name] and the staff team. I feel when reporting things, steps have been taken to change things. Things are going pretty well. We have a strong staff team."

At the last inspection on 8 November 2016 we found the registered provider was not acting on concerns about the building in a timely manner. We told the registered provider to make improvements and they sent us an action plan to show what they would do and when they would meet the regulations. At this inspection we found improvements had been made in almost all areas.

The regional operations manager said the service aimed to ensure people felt happy, safe and cared for, to promote independence and for people to progress to supported living, where possible. The registered provider held regular managers' meetings and training to help managers keep up to date with good practice. This meant they were open to new ideas and keen to promote learning to ensure the best outcomes for people using the service.

The management team worked in partnership with community health professionals to meet people's needs and drive up the quality of the service. We found there was never any delay in involving partners to ensure the wellbeing of the people living at the home.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on. House meetings were held on a monthly basis in each unit and topics discussed included activities, work placements, damage to property and holidays. Questionnaires about the quality of the service were also completed with people every six months to seek feedback and we saw this was largely positive and where issues were raised, action had been taken by the former registered manager.

Anonymous questionnaires were sent out to family members and professionals every six months by the registered provider and feedback had been acted on.

Staff meetings were held approximately every month. Topics discussed included maintenance and cleaning,

incident reports, healthy eating, training, care plans and health and safety. Actions from the last meeting were discussed and goals were set from the meeting. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

We saw audits were maintained in relation to premises and equipment. There was evidence of internal daily, weekly and monthly quality audits and actions identified showed who was responsible and by which date. Audits of medicines, health and safety and service users' money and infection prevention and control were conducted. Care plans and documents were also reviewed and audited frequently. The area operations manager completed random spot checks on staff practice on their regular walk rounds. Daily handover records were used to ensure tasks such as cleaning were completed, although these were signed by staff, some task had not been completed weekly as required, such as defrosting the freezer. This showed that whilst staff compliance with the registered provider's procedures was monitored, there were occasional gaps.

Since our last inspection regular supervision had been held with the registered manager during the area operations manager visits to the service. The regional operations manager previously visited the home every month to complete audits and ensure compliance with the registered provider's policies and procedures. Information was passed to the registered provider regularly regarding incidents, complaints, supervision, health and safety and other issues. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation.

Notifications for all incidents which required submission to CQC had been made, and additionally, all incidents of restraint had also been notified to CQC. One notification of serious injury had been missed when the registered manager was absent from work and the serious injury was investigated by the area operations manager and the local authority safeguarding team and appropriate action taken by the registered provider to ensure the person was kept safe.