

Real Life Options

Real Life Options - 12 Linden Road

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?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 22 and 23 February 2016. The first day was unannounced which meant the staff and registered provider did not know we would be visiting. The registered provider knew we would be returning for the second of inspection.

Twelve Linden Road can provide accommodation for up to six people who live with a learning disability. It is a purpose built detached house in its own grounds within a residential area of Brotton. Care and support is provided to people on both floors of the service which can be accessed via stairs. At the time of our inspection there were six people living at the service.

The registered manager had been in place at the home for many years. 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.

We previously inspected this service on 17 January 2014 and found that the service was meeting all of the regulations we inspected on that occasion.

All safeguarding incidents had been logged on the local authority's consideration log which the service updated every month. Separate safeguarding alerts had not been made.

Each person had a Deprivation of Liberties Safeguard in place to keep them safe from harm. We could see that these had been carefully considered to look at the least restrictive options.

Accidents and incidents had been reported and appropriately investigated.

People had risk assessments and personal emergency evacuation plans in place.

Staff told us they felt confident in dealing with an emergency situation and had received up to date first aid training.

There was enough staff on duty to provide care and support to people. Staff levels changed to accommodate people's individual needs.

Staff had been appropriately recruited. Disclosure and Barring Service checks and references had been sought prior to employment.

Staff had been appropriately trained to dispense prescribed medicines which people received on time.

Most certificates for the day to day running of the service were up to date; where two had expired we saw

that the registered manager had booked these in with the appropriate services.

Staff training was up to date. All staff received regular supervision and appraisals. Staff told us they felt supported to carry out their roles at the service.

A four week menu was in place, however alternatives were always available. People were supported at mealtimes and monitoring was in place to ensure people received appropriate nutrition and hydration.

People were regularly supported to attend appointments with a variety of health professionals including their GP, dentist and optician.

There was a communal living and dining room at the service; each person had their own bedroom which had been decorated to their individual wishes.

Staff showed kindness and compassion to people. They gave people the time they needed and were not rushed.

Staff involved people in any decisions made during their day. Staff gave explanation and used appropriate communication methods to interact with people.

People had been able to access an advocate to speak on their behalf when they had needed to.

Staff provided detailed examples about how they maintained and respected people's privacy and dignity.

Staff supported and encouraged people to maintain contact with those important to them.

Care records were very detailed and reflected people's wishes, preferences and daily routines. This meant staff could provide the most appropriate support to people when, and how they wanted it.

People were encouraged to give feedback generally and in reviews of their care. Staff made sure people's care reflected their individual needs and choices.

There were some gaps in records looked at during inspection.

Where complaints had been received they had been acted upon and records showed the action which had been taken to address the complaint.

The service worked alongside other organisations involved in people's care and made sure communication between services was transparent.

People participated in regular activities in the community and were supported by staff.

Staff spoke positively about their role at the service and all told us they enjoyed working at the service.

Staff told us they felt anxious about proposed changes to their contract and felt uncertain about their future at the service.

Staff spoke positively about the registered manager. They had been in post at the service for many years. The registered manager was responsible for managing three services. We questioned the appropriateness

of this because the demands of this outweighed the resources of the registered manager.

Regular meetings for people and staff took place at the service. This meant people were kept informed.

Some audits had been carried out; however there were no audits for care plans or record keeping which would have highlighted some of issues in this report.

Safeguarding incidents and accidents and incidents had been investigated.

CQC had not been notified of all safeguarding incidents at the service.

We found one breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to records and one breach of regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009 because we have not always been notified of safeguarding incidents at the service. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

Safeguarding training was up to date and staff understood the procedure they needed to follow to keep people safe.

Risk assessments were in place and identified the actions needed to keep people safe.

Medicines were managed appropriately. There were sufficient stocks in place.

Is the service effective?

Good ●

Training, supervision and appraisals were up to date

People were supported with menu planning. Nutrition and hydration were monitored and action taken when needed.

Deprivation of Liberties documentation was appropriate and up to date.

Is the service caring?

Good ●

Staff understood people's individual needs and this was reflected in the care given.

People's privacy and dignity was maintained.

Staff communicated with people using techniques appropriate to each individual person.

Is the service responsive?

Requires Improvement ●

There were gaps in some of the records looked at during inspection.

People were involved in activities at the service and in the community.

When people had made complaints they had been investigated appropriately.

Is the service well-led?

Requires Improvement ●

Notifications had not always been made to CQC.

Staff enjoyed working at the service and spoke highly of the registered manager.

The registered manager was responsible for managing three services.

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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.

One adult social care inspector carried out this unannounced inspection on 22 and 23 February 2016.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning officer from the local authority commissioning team about the service.

The registered provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection, we spoke with the registered manager and five members of staff. We spoke with two people who used the service, however they had limited communication skills which meant that minimal feedback was obtained and we spoke with two relatives over the telephone. We reviewed two care records in detail and records relating to the day to day running of the service.

Is the service safe?

Our findings

All staff we spoke with told us they felt people were safe living at the service. We gave one person who used the service a written question asking if they felt safe living at the service and they wrote down "Yes." When we spoke with one person's relative they told us, "The care is excellent. I have no complaints. They are safe living at the service."

We looked at safeguarding incidents which had been recorded between September 2015 and February 2016. We could see that there had been 11 incidents which had been recorded onto a local authority consideration log which the service was required to submit each month. When we looked at these we could see that safeguarding alerts had not always been made to the local authority. Following our inspection, we spoke with the local authority safeguarding team about this. They told us they would be in touch with the service to discuss when safeguarding alerts should be made

All staff spoken to during inspection provided detailed examples of the abuse which people living with a learning disability could be subject to; what signs of abuse could be seen within this particular group of people and how it could affect their behaviour. All staff were up to date with training and were knowledgeable about the procedure they needed to follow if they suspected that someone may be subject to abuse. All staff told us they felt able to raise a concern and would have no hesitation in whistleblowing [telling someone] if they needed to.

Accidents and incidents which had occurred at the service had been recorded, however there were gaps in records looked at. We could see that investigations had been completed and signed by a staff member. We could see that an analysis of these was carried out each month to identify any patterns and trends which would allow the service to take appropriate action to minimise the risk of harm to people and staff.

People had a large number of risk assessments in place, for example, in one person's records they had 29 risk assessments and in another person's record they had 24 risk assessments. We found that many of these risk assessments covered similar areas, for example, there were three risk assessments for finance, ten risk assessments for personal care and five risk assessments for going out into the community. Each risk assessment identified hazards, assessed the risk of harm and considered the control measures and actions which needed to be put in place to reduce the risk. Risk assessments had been reviewed each month and signed by staff. Risk assessments relating to the day to day running of the service were in place for things such as infection control, slips trips and falls, moving and handling, hot water and chemicals. Risk assessments had been regularly reviewed.

One person had a plan in place to manage behaviours which could challenge. This outlined the action staff needed to take to help the person to remain safe and minimise the risk of harm to other people who used the service and staff. This plan included triggers and behaviours; distraction and de-escalation techniques.

Each person had two personal emergency evacuation plans in place, one for day and one for night. Within these records was information about the person's understanding and the support they may need. This

meant staff and emergency service had the information they needed to evacuate people safely.

We looked at fire safety records and found that the local fire authority visited the service in 2015. They made a number of recommendations which we could see the service had addressed. A fire evacuation procedure had been put in place and planned fire drill had taken place in January 2016. There were no records to show that a planned fire drill had been carried out before this time. Fire checks of fire doors and fire alarms were carried out each week.

We were not able to look at records relating to recruitment (application forms and contracts, for example) because they were kept at head office. Records available on site showed that applications for employment had been made. We could see that two references had been checked and a Disclosure and Barring Service check had been carried out prior to employment. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

All staff spoken to during inspection told us that there were enough staff on duty throughout the day and night. They told us that staffing levels changed to meet people's needs and daily activities. One staff member told us, "I have no concerns about staffing. We have two relief staff now and they cover shifts when we need them to."

Only staff trained to dispense medicines to people did so; each of these staff members were also subject to yearly competency checks. This meant the service made sure people were receiving their medicines from appropriately trained and competent staff. An up to date medicines policy was in place. At the time of our inspection, there were no controlled medicines or homely remedies in use at the service. Medicine room temperature records were completed each day; this meant there were appropriate check in place medicines were stored in a way that kept them safe for use.

Some medicines arrived in a medi-pack and other medicines needed to be ordered by staff. We looked at the prescribed medicines of two people who used the service. We could see that there were sufficient quantities of each person's medicines in stock. This meant that staff took appropriate action to make sure people had the medicines they needed. When medicines were received into the service, staff updated the records. We checked prescribed medicines and found the quantities matched the numbers recorded on the medical administration records (MAR).

Some people were prescribed 'as and when' (PRN) medicines. We could see that protocols were in place for each of these medicines. Protocols detailed how and when prescribed medicines should be given and also included signs and symptoms associated with the need for these medicines. When PRN medicines had been given to people by staff, the records were appropriately completed.

There were up to date certificates in place for gas appliances, electrical goods and PAT testing had been carried out. We could see that most certificates were in place for equipment which was used at the service. We could see that two certificates for hoists had expired, however the registered manager had booked in appointments for these hoists to be serviced.

Is the service effective?

Our findings

All staff were up to date with training; this included things such as health and safety, infection control, management of behaviours which can challenge, fire safety and moving and handling. We could see that it had been more than three years since staff had undertaken training in autism. It is good practice to refresh training regularly to make sure staff are up to date with any changes. We could see that some staff were booked onto training. The registered manager told us that all staff would be completing this training over the coming year.

All staff had participated in an induction when they started work at the service. We could see that induction covered a number of areas which included getting to know people, duty of care, equality and diversity, privacy and dignity, nutrition, safeguarding and first aid. Staff spent time shadowing experienced members of staff and familiarising themselves with people's individual routines, likes and dislikes.

All staff received regular supervision and appraisals. This meant that all staff were supported to carry out their roles appropriately. Both supervision and appraisals were carried out in line with the registered providers policies.

Staff told us that the menus were regularly changed and were based on the foods people liked. One staff member told us, "We have to support people to make healthy choices." Another staff member told us, "The food here is ok. People have lots of choice about their meals. If we make something and people don't want it we will offer something else. [Service user] is funny about eating vegetables, they would eat pastries everyday if they could but we need to make sure people eat healthy choices. We saw that people could have something else if they didn't want the food that was provided. Staff monitored portion control and what people had consumed. This meant that staff could take appropriate action if people were at risk of malnutrition. Some people needed to have their fluid intake monitored which staff recorded on a white board each day. This information was wiped off at the end of each day and not permanently recorded. We spoke to the registered manager about this and they told us they would action this straight away.

People had regular contact with health professionals which included their general practitioner, dentist, optician, chiropodist and district nurse, for example. People had received an influenza vaccination and best interest decisions had been carried out for this.

Staff told us about how they worked alongside health professionals to maintain the health and well-being of the people they cared for. One staff member told us about the action they took when an area of one person's skin became inflamed and they thought this could develop into a pressure sore. The staff member told us, "We got in touch with the district nurse and followed their advice. We used the cream each day; we caught it at the right time and the skin didn't break. The needs of [service user] changed so we got in touch with their social worker and reviewed their care. We were able to get this person en-suite facilities and a ceiling hoist."

One staff member told us that one person was at risk of urine infections, they told us about the action they

took when they suspected the person might be at risk. They told us, "When [service user] urine is dark, we ring the GP and send in a sample. We increase fluids and follow what the GP tells us."

Each person had a hospital passport in place. This is a document which goes to hospital with people and gives hospital staff information about the person, such as their health conditions and medicines, but also what the person likes and dislikes and how to communicate with them. Information about individual routines is also included. This is particularly important for people living with a learning disability. Hospital staff can use this information to consider how they can communicate with people to minimise any distress or misunderstanding.

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

At the time of our inspection, there were six people who had a DoLS restriction in place; we could see that people had these in place to maintain their safety or to provide support with personal care, eating and drinking and medicines management. The service had a record in place which showed when each person's DoLS restriction had been granted and when it was due to expire. This prompted the service to make sure that a review of these deprivations took place prior to the expiry of the restriction. The registered manager notified CQC when DoLS authorisations had been granted.

Consent forms for a key safe had been signed by people. We could see that one consent form had been signed by the person's mother because they were not able to sign themselves [due to their health condition]. Records detailed the specific reasons for this and we could see that the person had been able to give verbal consent but not written.

There was one bedroom on the ground floor and five bedrooms on the first floor. There was a communal lounge and dining room and people had access to a large garden. We looked in one person's room with a staff member and could see that this person's room had been adapted for their individual needs and included an en-suite bathroom and ceiling hoist. The staff member told us, "This room gives [service user] independence. It makes our job must easier and [service user] has not shown any nerves from using the hoist.

People's bedrooms had been decorated to their own individual tastes and staff told us people were involved in deciding the colour of the décor and the accessories they wanted in their rooms. We could see that walls in communal areas of service had been painted but wood work had not. When we spoke to the registered manager about this they told us they would make arrangements for this work to be carried out.

Is the service caring?

Our findings

We observed staff giving people the time they needed when carrying out personal care. We observed a staff member assisting one person to put on their footwear. The staff member spoke positively to this person and gave reassurance. The staff member said, "That's good. They really go with your outfit" and "Do they feel ok?" All staff appeared to show genuine concern and compassion for people who used the service. One staff member told us, "I like my job. I love supporting our service users, getting them out and seeing them happy." Another staff member told us, "We always try to take people out. We make sure they are clean and well fed." One relative told us, "[Service user] is always well dressed. They choose their own clothes. Sometimes you wouldn't expect things to go together but they always look good."

When we spoke with relatives, we could see that they were happy with the care and support which their relatives received. One relative told us, "I am happy with the care [service users] gets. The majority of the staff are caring and capable. The staff have [service user] best interests at heart and [service user] is extremely happy. They get to go out and have a plan of activities each week." One staff member told us, "We follow people's support plans. We make sure we are familiar with them. We can then help people and encourage them to do things for themselves." One relative told us, "The staff are always thinking of new things for [service user] to do. [Service user] packs their own lunch, now staff have got them shopping for their packed lunch." One staff member told us, "People are well looked after here. I have no concerns at all." Another staff member told us, "We offer person centred planning and support to service users. We make sure they do what they want to do. We make sure people get the appointments they need to look after their health."

Everyone at the service has limited communication skills. We could see from our observations that staff knew people well and knew how to communicate best with them. We saw staff communicating with people in different ways. We wanted to talk with one person and we asked a staff member for assistance. We observed the staff member sit next to the person and used their hand to touch the other person's hand to gain their attention. We watch as the staff member faced the person and asked if they were safe. The staff member told us they did this because the person could lip read and it was important to gain their attention to do this. The staff member wrote a question down on a piece of paper in a large font and passed it to the person. The staff member gave the person the time they needed to write down an answer. When the person dropped their pen, the staff member assisted them to pick it up and hold it steady; the staff member allowed the person to do this rather than to take over. We asked this person if the staff were nice to them and then wrote "Yes" on our piece of paper. We also asked if they were happy at the service and they wrote "Yes" on our piece of paper.

Policies and procedures were in place for privacy and dignity and all staff had received up to date training. Throughout our inspection, from our observations and discussions with staff we could see that staff always tried to protect and maintain the privacy and dignity of the people they provided care and support to. One staff member told us, "We always close doors when providing personal care." Another staff member told us, "I always close doors to protect people's privacy. When I hoist [service user] I speak to them and tell them what I am doing. I feel that this offers them reassurance." Another staff member told us, "We lock doors and

close curtains to maintain people's dignity. We have private discussions behind closed doors. When we carry out personal care, we explain what we are doing, for example, I say 'I'm putting my gloves on now' and will say why."

Staff appeared to care for people. Staff told us that they had to speak up on people's behalf because they were not able to do this themselves. They told us that because people had limited communication skills they needed to make sure people's voices were heard. All staff spoken to during our inspection told us about the different choices people had. We also observed this when we spent time with people who used the service. One staff member told us, "People have choice about everything. They decide what they want to do with their day and can decide when they want to come back." One staff member told us, "We fight for things for people. We spoke with [service user] family to arrange a pass for the gym. They now go three times per week. This meant we were able to increase their activity timetable."

Staff told us that some people living at the service can display behaviours which can challenge. Staff told us they had undertaken training and followed advice from health professionals. One staff member told us, "We know when people need more support from us or when they need space. We always make sure staff are around so we know what's going on. We use the 'Caring Cs' [Team teach positive handling strategies for managing behaviours which can challenge]."

Staff supported people to keep in touch with people important to them. One relative told us, "[service user] sees me every two weeks. The staff bring [service user] by taxi every two weeks and phone every week. [Service user] can't talk to me but I can speak to them. We have a giggle and a laugh. The staff always ring me, they take on the family not just the people."

Staff told us that some people had accessed the use of an advocacy service to speak on their behalf. One staff member told us, "[Service user] has no family so we decided along with their social worker that they needed someone to help them to make decisions and speak up for them."

Is the service responsive?

Our findings

We identified gaps in some of the records which we looked at during our inspection. We found that some of the support plans in place for one person lacked information. We could see that some of the sections within these plans had been completed and in other relevant sections, staff had recorded 'Not applicable.' This meant that appropriate information was sometimes missing from the records. A plan to manage behaviours which could challenge had not been updated since 23 December 2013. This meant that we did not know if the information contained within this plan remained relevant. There was a record in place where staff were required to sign to say they had read and understood the plan. We found that this record had not been completed by any staff member working at the service. In one person's records, a speech and language therapy assessment stated that this person should be assisted to change position every two hours to minimise the risk of a pressure sore. There was no evidence to suggest this had been carried out by staff. When we spoke to one staff member, they told us that this was no longer relevant because pressure relieving equipment was now in place for the person. We saw that the records had not been updated to reflect this information.

Monthly reviews for each person had been carried out between August and December 2015 for one person; however reviews for January and February 2016 had not been completed. This meant the service had not kept up to date with people's reviews. We also found that a quarterly support meeting to look at people's achievements had not been carried out on 09 February 2016, [or since this time] when it was due for review. The purpose of this review was to look at what the person had achieved and where further support was needed.

Staff completed learning logs for people which were linked to their support plans. There was no information about the frequency of which learning logs were carried out. We found that these records were not always completed appropriately, for example questions were not always answered appropriately or had 'Not applicable' recorded when the questions were relevant. One question asked what did the person like about the activity and 'Not applicable had been recorded.' This meant staff were not appropriately completing records or considering whether the activity was suitable or considering the learning from the activity.

Monthly weight records had not been completed every month. Where weights had been recorded, gain and loss and Body Mass Index (BMI) was not always recorded. This meant staff had not considered whether these people's weight or BMI had increased or decreased. In one person's record, a decrease in weight had been incorrectly recorded; when we looked at the figures we could see there had not been any decrease in weight.

Whilst risk assessments had been reviewed each month, the records did not show any evidence of a review other than a date and signature. We could see that information had been crossed out within the record. There was no detail about what was discussed or consideration in the review of each risk assessment and whether the risk assessment remained relevant.

Hospital passport had also been reviewed regularly but there was no evidence of a review. We could not see

if information had been updated. In one person's hospital passport, we could see that it had been reviewed in January 2016 however the last health check recorded in this passport was dated February 2011. This meant we did not know how relevant the information in this hospital passport was.

An accident record dated 27 January 2016 stated the type of injury which had occurred and had been signed by a staff member and the registered manager. However there were no details about how the injury occurred. This meant that we did not know if an investigation took place and what the outcome of this investigation was. On each accident record, there was a 'Section F: notifications' which staff were required to complete to show if people such as the regional manager, health and safety team, family, regulator and local authority needed to be informed. We looked at ten accidents and recorded between 24 September 2015 and 17 February 2016 and found that this section within each of these records was not fully completed. This meant that we did not know if staff had notified the appropriate people of accidents which had occurred at the service.

Risk assessments for the day to day running of the service had been completed in January 2016 and a staff signature was recorded, however there was no evidence of a review. New records had not been completed. This meant we did not know if potential risks had been reviewed appropriately. Six risk assessments were in place for possible risks at night. A record was in place for all staff to sign to say they had read and understood these assessments. We found that all staff had not carried this out.

There were gaps in the supervision and appraisal records in the four staff records which we looked at. We could see that some sections were not always completed appropriately or were left blank. This meant it was not always clear if staff were demonstrating their ability to achieve the competencies outlined in the supervision and appraisal records or if any progress had been made. We found that 'reviewee summative comments' were often left blank. When we spoke with the registered manager, they told us, "Staff are often reluctant to complete this."

This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had a one page profile which provided information about how to support the person, what was important to them and what people would say about them. This was useful information to assist new staff and can provide useful prompts about topics of conversation.

Each person had daily support plans in place. These had been developed over the years as staff became more familiar with people and their individual needs. Staff did try to include people in these developing care plans, however people had limited communication skills and were not able to understand complex information. Staff told us that they involved people where there were able to and often referred to relatives and health professionals involved in people's care to make sure planned care was right for each person. One staff member told us, "People soon let us know if they don't like something. If it's food for example, they will push it away. This means that we will offer something different. It can be trial and error at times." Daily support plans were very detailed documents which gave staff the information they needed to provide the most appropriate care and support to people. There was information on the routine staff needed to follow which was individual to each person. Within this information were details about what equipment to use and what each person could understand. Support plans included information about how each area within the plan should be achieved.

Monthly consultations were carried out to review each person and included things such as activities, health, finances, risk assessments and future goals. We could see that staff were prominently involved in these

reviews, however relatives were invited once per year.

Quarterly support meetings were carried out to look at people's achievements, what had worked and what had not worked over the last three months. Actions and timescales for completion had also been addressed. We could see that one person had a review on 09 November 2015 and their next review was due 09 February 2016. We could see from the care records that their review had not been carried out.

Daily records were completed three times per day by staff. These records held information about how the person had been throughout the day, the activities they had been involved in and details which reflected their individual support plans. We saw that there was guidance in place to assist staff with completing daily records. This meant the service were supporting people to complete these records appropriately. Handover records were completed each day by staff. This meant that staff coming on duty after annual leave or days off could be given a quick update of important information.

Each person had an activities plan in their care records which were individual to them. We could see that people participated in activities at the service such as playing cards and dominoes or watching television. People were also involved in activities associated with the day to day running of the service, such as helping staff to maintain their rooms and carry out their laundry. Each person took a turn in assisting staff to carry out the weekly shop at the local supermarket. People regularly accessed the local community to eat out, go to the gym, visit the cinema or go to the local football match. One staff member told us, "People have lots of choice about how they want to spend their day." Staff carried out activities with people to maintain their health and well-being, for example, one person was given regular leg massages to increase blood flow. One staff member told us, "We involve people in person-centred activities. [Service user] has a season ticket and staff go with them to all matches. They really enjoy it. When they win they have such a smile on their face." One relative told us, "[Service user] has a good social life. They go to the cinema and the youth club. They are never in. They also go to the day centre five days per week. [Service user] has a better social life than me."

One staff member told us they helped to organise activities for people. They told us, "I love organising things. I arranged for people to see a Pantomime in Redcar and recently I have gotten [service user] into bingo at our local community centre. We have also been to EarthMed shows in Saltburn which are shows specific for people with a learning disability. I get a lot of satisfaction out of doing things for people."

All staff spoken to during inspection, told us that the loss of the communal car at the service had impacted upon the availability of activities. Staff told us they were more limited to activities on bus routes and were no longer able to go for walks on the moors for example. One staff member told us, "We are really limited with the activities we can do at night because the bus service stops early in the evening. We used to go to Teesside Park at night but we can't do this anymore." Another staff member told us, "I wish we could have our car back so we can take people out to different places, or even for the company to pay our mileage [to use own cars]. It's not nice when the weather is bad and you have to stand waiting for a bus. If it's raining people get wet. They can get changed when we get back [to the service] but staff can't. We have to work the rest of our shift in wet clothes." Another staff member told us, "I think it is bad not having a car. [Service user] is autistic and has to go out into a noisy environment now. They have just about coped, although we have had a couple of incidents where people's bags have been ripped on buses. [Service user] doesn't like the bus, but they are ok in a taxi. [Service user] is bad at walking. We can be delayed waiting for the bus which makes walking difficult." Another staff member told us, "Losing the car has been rubbish. People miss the car. Public transport is hit and miss. People are missing out and some people don't like waiting. [Service user] goes to Great Ayton. It used to take us 40 minutes in the car but now takes us two and a half hours on the bus."

A complaints policy and procedure was in place, however the registered manager told us that no complaints had been received during the 2015 last year. Staff were aware of the action they needed to follow should they receive a complaint. Each person had a copy of the complaints procedure in their own rooms in an easy read format. One staff member told us, "People here wouldn't understand what was written in them." One relative told us, "I had needed to put a complaint in previously. It was resolved and I was happy with the outcome."

Is the service well-led?

Our findings

We looked at safeguarding incidents which had been logged onto a local authority consideration log between April 2015 and February 2016. We could see that all safeguarding incidents had been logged on this, but safeguarding alerts had not been made when needed. When we spoke with the registered manager about this we could see that there was a lack of understanding about what needed to be recorded on a consideration and log and when a safeguarding alert needed to be made. This also meant that the registered manager had not always submitted a CQC notification in respect of a safeguarding alert. We looked at 11 safeguarding incidents and found that for six of these no CQC notifications had been made.

This was a breach of regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009. We will take action to address this outside of our inspection process.

Staff spoke positively about one another and felt part of the team they worked in. One staff member told us, "The staff team are lovely here." Another staff member told us, "Most people have worked here a long time. All of the staff are brilliant. We fight for what our residents need." We could see that staff had been in post for many years and knew people well. One staff member told us, "I've been here a long time and have no intention of leaving." Another staff member told us, "I have worked here for many years. I enjoy the challenge of the people who we look after and moulding them into something better. I also enjoy taking people out into the community and on holiday." One relative told us, "The staff are wonderful. Most of the staff have been here a long time, like family, [Registered manager] is absolutely passionate about people." When we spoke with people's relatives we found they were complimentary about staff and valued the staff team. They spoke about the importance of familiar staff and appreciated the low staff turnover. One relative told us, "Nothing could be improved. It's a miracle service. They work as a family and there have been no real changes to the staff which is good. I am always made to feel welcome."

All staff we spoke with felt able to raise any concerns with the registered manager and felt listened to. They all felt able to do this in team meetings, supervision or when needed. One staff member told us, "[Registered manager] responds to any complaints or concerns which we have." When we spoke to staff and asked about the registered manager, people spoke positively of them. One relative told us, "The manager is very good. I have confidence in them." We could see that the staff team felt able to carry out the day to day running of the service under the guidance from the registered manager. We observed the staff team on both days of our inspection working together to ensure the smooth running of the service. One staff member told us, "We all know what we need to do. We have one person leading each shift and I like that."

All staff spoke highly of the registered manager but expressed genuine concern about the volume of work expected by the registered manager. At the time of our inspection, the registered manager was responsible for managing three services. From speaking with staff we could see that the registered manager visited the service everyday but was often described as being 'in and out' or 'in the office catching up on paperwork.' One staff member told us, "The manager spends time here. They are based here. [Team coordinator] is never here." One staff member told us, "[Registered manager] will do anything for anyone. All this running about will affect his health."

We looked at a complaint which a relative had submitted to the service. One of the points within this complaint was regarding the lack of management presence at the service. In response to this, a decision was made for the team leader to base themselves at this service each Monday. From looking at the staff rota and from speaking to staff we found that this was not the case. When we spoke to the registered manager they told us, "From the complaint the agreement was [Team leader] would go to Linden Road each Monday which did happen. Although this changed recently because I am already in the area. I have been going to Linden Road myself. This will change shortly and the team leader and I will be spending two and half days at this service and two and a half days at our other service.

Care staff told us about proposed changes to their roles and felt that they had been a lack of communication. As a result of this they felt disheartened. Staff told us, "This makes me feel like I want to leave." And "I'm just a number. I feel very disheartened because of these proposed changes. I love working here. Morale for our service users is good, but it is poor for the company." We discussed this with the registered manager who told us they were aware of this and action was being taken to address this.

Weekly audits were carried out by staff which was a checklist of tasks which staff needed to carry out. This included checks of cleaning records, food safety, fire alarm, wheelchair checks, water temperatures, daily notes, food consumption and medicines audit. From the records which we checked, we could see that the service had kept up to date with carrying these audits out each week. However there were gaps in these audits. We checked records between 06 December 2015 and 10 February 2016 and identified regular gaps in safer food records and menus as part of this weekly audit. We could not see if these weekly audits had been checked by a member of the management team because no action had been taken to address these regular gaps. Weekly medicines audits were also carried out and included any changes to people's medicines. However, in a medicines audit dated 08 January 2016 the record stated that there were excess prescribed medicines for two people however the audits did not show what action had been taken to address this. A monthly health and safety audit was a checklist of tasks or questions which staff needed to check and complete; this included checks of the first aid box, fire exits, furniture, wheelchairs and hoists for example. Actions identified in quarterly health and safety audits dates 07 October 2015 and 26 January 2016 did not show if the actions identified had been addressed. There were no record keeping audits carried out at the service which would have helped to identify the gaps which we highlighted during our inspection. This audit would have allowed the service to identify action needed.

A survey had been carried out nationally by the registered provider. The results of the survey were based on national results; this meant we could not see which results were relevant to this service and what action was needed in relation to this service. We also did not know if results had been disseminated to people and their relatives. There was no evidence of actions needed from this survey.

Regular staff meetings were carried out and well attended by staff. We saw that agendas were sent to staff prior to meetings. During meetings, updates from the managers meetings were discussed as well as quality assurance, safeguarding and health and safety. Regular meetings for people and their relatives were held during the last year. We could see that confidentiality; bullying, menus and decoration had been discussed. We could see that an action plan had been developed from this. The registered manager told us that feedback from people and their relatives was sought generally and through person-centred reviews.

The service worked well with other agencies involved in people's care and from the records and speaking with staff we could see that they followed the advice given to them. Staff told us they felt able to pick up the telephone and ask questions when needed. From our inspection, we could see that staff acted when needed to maintain the quality of people's health and well-being.

All staff understood the role and responsibilities expected of them and carried out their roles appropriately in the absence of the registered manager. Staff understood what they were accountable for and when appropriate sought advice from the registered manager as part of a decision making process.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always completed appropriate and there were gaps throughout records look at.