Caretech Community Services (No.2) Limited

May Lodge

Inspection report

Barrow Hill
Sellindge
Ashford
Kent
TN25 6JG

Tel: 01303813926

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 15 August 2016. May Lodge is a care home which provides care and support for up to 6 people with learning disabilities or autistic spectrum disorder with additional physical disability needs. The service is located in bungalow accommodation and fully accessible for people in wheelchairs. The service is set within residential housing but is set back from a busy road and off street parking is available.

At our previous inspection of this service in February 2016 we found the service was not meeting the required standards of quality, safety and personalisation of care and support to the person living there at that time and there were significant shortfalls, the service was placed into special measures. We took enforcement action against the provider and asked them to tell us what they were going to do to put the shortfalls right. Since that time the provider has kept us informed regularly of progress they have made towards meeting the required standards. This inspection was to assess whether the improvements they had told us about had been embedded and were now everyday practice.

At the time of our inspection a second person had been admitted within the past week and a third had been assessed and was commencing transition to move to the service. People were unable to tell us about their experience of care but when we met them they were relaxed in the company of staff and in good moods. A relative spoke positively about the quality and delivery of care provided by staff to their family member.

A registered manager had not been in post since December 2015, although there was an on-going recruitment for this. A registered manager is a person who is 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.

Our inspection highlighted that whilst there had been significant progress made there were still shortfalls that needed further work to evidence they fully met the requirements of some regulations. The use of medicines in the service had been minimal with an occasional 'as required' medicine used, however with the admission of more people there was now a need for staff to administer prescribed medicines and we noted some shortfalls within the current system that needed to be attended to. A framework was in place for the assessment of both individual and environmental risks to ensure people were kept safe but there were some risks that had still to be assessed and this could place people at risk of harm.

People referred to the service were assessed prior to admission and a programme of transition implemented to enable them to familiarise themselves with the new service; some key information however, had still not been sufficiently detailed about people's needs and this left staff still asking questions in relation to needs and support around this. Staff said access to training had improved but some important relevant courses were still outstanding for some staff.

Quality audits were in place but not always carried out robustly or evidenced clearly that actions had been taken to provide assurance that the service was meeting standards.

Staff had an understanding and awareness of the Mental Capacity Act, capacity assessments were being undertaken but staff did not recognise that some of their practice could be considered as restrictive and should be discussed within a best interest discussion. Staff respected people's choices but there was a risk their privacy could be compromised without appropriate equipment to alert them to the presence of others. A lack of skilled communication by staff could lead to isolation for some people. People were consulted about their menu choices but there was some repetition in the meals provided to them on some weeks.

Incidents of behaviour which challenged were assessed and trends and patterns informed the development of guidance and strategies for staff, however these were overdue and staff still lacked confidence in managing incidents that were very challenging at times.

There were enough staff to keep people safe and the number of staff would increase as new people were admitted. Recruitment procedures ensured that appropriate checks were made of prospective staff in accordance with requirements of the legislation. Staff said that the improved interim management arrangements made them feel better supported and more confident when issues arose that they wanted or needed guidance and support with. They had regular opportunities through staff meetings and individual supervisions to express their views and receive support around their training and development. New staff received induction and were registered for the care certificate but still to commence this. Staff had not been in post long enough to have their performance appraised but new staff experienced a probationary period when they met with a member of the interim management team to discuss their progress.

There had been no complaints and relatives told us they felt confident of making a complaint should they need to do so. The complaints procedure was clearly displayed within the service and an easy read version available, the provider recognised this needed further revision to meet the needs of people in this service.

A comprehensive care plan had been developed to inform staff how to provide support to people in accordance with their needs and wishes. Improvements had been made to range of activities provided to people and transport was available to enable them to go out into the community; each person was provided with an individualised activity schedule that reflected their interests.

The premises were well maintained a maintenance team provided appropriate support for repairs and servicing checks and tests of equipment were completed within timescales. Fire procedures and evacuation plans were understood by staff and they understood how to protect people from harm and keep them safe, but we have recommended discussion around personal evacuation plans with the fire service. Peoples general health needs were supported and appropriate referrals made to health professionals for support and advice.

Peoples relatives were made welcome and people were supported to maintain contact with important people in their lives. Relatives felt informed.

Updated policies and procedures were in place and staff had been asked to read and sign that they had read those relevant to their role and support of people. The management staff understood their responsibilities to alert the Care Quality Commission to events in the service but had not had to do so to date.

People were supported and enabled to develop independence skills. They were supported to personalise

their own space. Key workers spent time with people to try and engage with them and listen to what they had to say or sign to them.

As this service is no longer rated as inadequate, it will be taken out of special measures. Although we acknowledge that this is an improving service, there are still areas which need to be addressed to ensure people's health, safety and well-being is protected. We identified a number of continued breaches of Regulations. We will continue to monitor May Lodge to check that improvements continue and are sustained.

We have made three recommendations:

We recommend that the provider seek advice from the fire service on the appropriateness of personal evacuation plans in respect of people being left behind fire doors in the event of a refusal to leave.

We recommend that the provider seek advice from a competent source regarding appropriate doorbell systems for hearing impaired people.

We recommend that the provider seek guidance from a competent source on the development of a suitable, appropriate and accessible complaints format for people with complex needs and very limited verbal skills.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe

Improvements were needed to medicine management. Some risks were not adequately assessed to keep people safe. Checks of equipment brought in by new people were not robust.

The premises were well maintained and all servicing checks and tests of equipment conducted within timescales. Fire procedures and evacuation plans were understood by staff, but personal evacuation plans should be discussed further with the fire service.

Recruitment procedures ensured relevant checks of staff suitability were made. There were enough staff to support people safely. Staff knew how to keep people safe from abuse. Accidents and incidents were managed appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective

Some important training to help staff support people safely and appropriately had not been provided to all staff. Improvements were needed to ensure new staff induction met the requirements of the care certificate. People were not supported in accordance with the Mental Capacity Act 2005 because some restrictions were not authorised.

Incidents were assessed and informed the development of guidance for staff in managing behaviours that challenged, but guidance was overdue and staff still lacked confidence.

Staff said they felt better supported and received regular supervision. Peoples general health needs were supported and they had access to healthcare when needed. People were consulted about what they ate.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff respected people's choices but there was a risk people's privacy could be compromised and the lack of skilled communication by staff could lead to some people becoming isolated.

Peoples relatives were made welcome and people were supported to maintain contact with important people in their lives. Relatives felt informed.

People were supported and enabled to develop independence skills. They were supported to personalise their own space. Key workers spent time with people to try and engage with them and listen to what they had to say or sign to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The needs of new people were assessed but there were still gaps in the information gathered and this impacted on the support staff provided.

An easy read complaints procedure had been developed but this needed further revision to meet the needs of people in this service. A comprehensive care plan had been developed to inform staff how support was to be provided.

Individualised activity planners that reflected personal preferences and interests were in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led

A registered manager had not been in post for more than seven months. Quality monitoring was in place but improvements were needed to how this was utilised to make it more effective.

There was better oversight of the service from new interim management arrangements. Staff felt better supported and participated in regular individual and group support meetings. Important events in the service were notified to the Care Quality Commission as required.

Policies and procedures were kept updated and staff made aware of any changes. Relatives commented positively about the service

May Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 15 August 2016 and was unannounced. The inspection was conducted by one inspector.

Prior to the inspection we had not requested the provider 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. We did however look at the information provided by the provider action plans submitted regularly as a result of the enforcement action we took. We also reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

At inspection we met both of the people who lived in the service. Sometimes people preferred their own space and found it upsetting if people they did not know visited and asked questions, so we were only able to observe people briefly in their interactions with staff, and for one person when they were using a communal space for a short period of time during which time we used the Short Observational Framework for Inspection (SOFI); SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported.

We spoke with an locality manager providing interim management support, the deputy manager, a behaviour therapist and four support staff. After the inspection we spoke with one relatives and four health and social care professionals.

We looked at one completed care plan and associated health plan, environmental and individual risk assessments, medicine records, and operational records that included three staff recruitment training and

supervision records, staff rotas, menus, accident and incident reports, servicing and maintenance records, complaints information, policies and procedures and survey and quality audit information.

Requires Improvement

Is the service safe?

Our findings

We observed people were relaxed and comfortable in the presence of staff who knew their needs well. A relative told us they were "thrilled with the cleanliness and overall appearance of the service" health professionals we spoke with felt the service was trying to work with people with very complex needs and that they still needed support around this. Staff told us that they were happier with the availability of 'management' staff on site and felt there was a better structure and lines of accountability.

At the last inspection we identified that the systems that were in place to help ensure people's safety required improvement. Following the inspection the provider took action to address the shortfalls we had identified, this inspection was to check these improvements had been implemented and sustained.

At the previous inspection staff had not needed to administer medicines so this had not been assessed at that time. Since then new people were being admitted who took regular medication and staff had been provided with basic medicines training so they could support people with this. The deputy manager had attended advanced medicine training to enable her to be able to undertake the ordering, receipt and booking in of medicines and to manage their disposal correctly, but had not yet been required to carry out these functions. Staff competencies in regard to medicine management were still to be assessed so in the interim medicines trained staff from an adjacent service were administering medicines to people at May Lodge. Peoples medicines were a mix of prescribed for everyday use and some 'as required'. We noted that not all medicines were dated upon opening which would help with auditing that the amounts of medicines used were correct we discussed this at inspection and this is an area for improvement.

Protocols for staff in regard to the administration of 'as required' medicines had not been developed this meant there was a risk that staff may not administer these medicines in a consistent manner and this could pose a risk of over or under medication. The failure to provide appropriate guidance to staff regarding peoples medicines is a breach of Regulation 12 (2) (g) of the Health & Social care Act (HSCA) 2008 (Regulated Activities) (RA) Regulations 2014.

In all other aspects medicines were managed well with appropriate security and storage, administration of medicines was undertaken at a pace to suit people with staff explaining to people what they were doing and providing them with a drink to enable them to swallow their tablets. Medicine records were appropriately maintained.

At the previous inspection we had raised concern that risks had not been appropriately assessed. Since then the provider had taken action to involve a range of health professionals to help with assessing and managing risks for the then only person in residence. The assessment of potential risks to new people admitted to the service as a result of their own specific needs or from the environment had not been assessed and this could place them at risk. For example a new person admitted was of low weight and at nutritional risk but a risk assessment had not been completed to indicate the level of risk and what measures needed to be implemented to help them maintain a healthy weight. The person had significant continence issues but an assessment of risk regarding their skin integrity had not been undertaken to assess

the level of risk and the appropriate risk reduction measures that were needed to protect them from a breakdown of their skin We also found that assessment of risks for the garden area had been overlooked because this had not been previously used, yet the garden contained some hazards for people newly admitted who were likely to use the garden. There was a failure to identify and address new risks and this was a continued breach of Regulation 12 (2) (a) of the HSCA 2008 (RA) Regulations 2014.

At the previous inspection we had raised concerns that risks of fire and other events that stopped the service had not been adequately mitigated. Since then all staff had received fire training and understood how to keep people safe in the event of a fire. Personal evacuation plans were in place for people but we would recommend these are discussed with the fire service to ensure they meet fire legislation; fire risk assessment and evacuation procedures were updated. Staff carried out weekly and monthly visual checks and tests of fire equipment; they participated in regular fire drills. A hearing impaired person had been provided with a flashing light linked to the fire alarm and also a vibrating pillow alarm to alert them in the event of a fire. Procedures were in place in the event of emergency events that could stop the service and this guidance was available to staff.

We recommend that the provider liaise with the fire service in regard to personal evacuation plans and whether they meet the requirements of fire legislation in respect of people who refuse to evacuate being left behind fire doors.

The premises were well maintained, clean and tidy. It provided a homely environment for people to live in. We did note that a mattress brought in by a new service user was not fit for purpose and asked the locality manager to look into providing a replacement at the earliest opportunity. This highlighted that the service should be more proactive in assessing the quality of furniture and equipment brought in to ensure people were not left with broken or damaged equipment for some time after their arrival until replacements were found; this is an area for improvement. Cleaning schedules were in place and servicing of heating, cooking and electrical installations was kept updated.

Staff had received safeguarding training that helped them to understand, recognise and respond to abuse, their competence and their understanding of this area was assessed. Staff were confident of raising concerns either through the whistleblowing process, or by escalating concerns to managers and senior staff within the organisation or to outside agencies where necessary.

Since the last inspection action had been taken to ensure that the information gathered about new staff met the requirements of regulation, staff files viewed confirmed that the provider had checked all the required information before appointing people to posts to ensure they were suitable.

There were enough staff on duty to meet people's needs. The current staffing levels comprised of a manager, deputy manager and four support staff, it was confirmed by staff present that whilst management support was only present during weekdays, support worker staffing levels were maintained throughout the week with access to on call managers if necessary.

People were supported by one to one staffing at the service, and two to one staffing when they went out. Staff were available all day to provide extra support for outings which occur most days. Staff did not appear rushed or hurried and were able to spend time to interact with people. People had become more settled and the level of night time checks had reduced in response. A waking night staff member undertook hourly checks. A sleep in staff member was available if needed.

There had been no accidents recorded although staff understood how to report these. Staff routinely

recorded incidents involving behaviour which were analysed by a behaviour therapist. Strategies were under development to help staff manage these situations better. Emerging trends determined whether a review of existing care plan, risk information or strategies for behaviour management were needed.

Requires Improvement

Is the service effective?

Our findings

A relative and health professionals expressed concern that the service had not progressed training for staff to help with signing for one person who used a mix of British Sign Language and Makaton. This had been identified as a shortfall at the previous inspection. Since then health professionals had discussed the need to focus on one form of communication this being Makaton and had offered training in this area, but this had not to date been taken up by the service. The provider had provided an in house communication workshop that all staff had attended, this was meant to help them with using common signs and providing them with a vocabulary of signs that could be used with the person they supported, staff were not confident this had been enough. Professionals and relatives were of the opinion that staff still needed to become more fluent in using Makaton, a relative commented from their observations when visiting "there is not a lot of signing going on". There was a risk of the person becoming isolated because their socialisation was dependent on staff interaction with them.

The majority of training had been provided through on line courses and staff understanding of what they had learned was assessed through short tests. Further assessment of their competency was being introduced through themed supervisions. Staff were up to date with their training and had also received practical moving and handling training using a hoist. The provider however, had not ensured that new staff commencing at the service were provided with this training upon starting their employment, one permanent staff member employed since May 2016 and also an agency worker were still to receive this training. Whilst it is acknowledged that staff worked in pairs and there were usually other trained staff on the rota, there was a risk that the health and safety of untrained staff and the person could be compromised.

Staff were not provided with the training necessary to undertake the safe and appropriate support of people in accordance with their needs, and wishes this is a continued breach of Regulation 18 (1) (2) (a) of the HSCA 2008 (RA) Regulations 2014.

We noted that when in bed one person's wheelchair was stored some distance away. This deprived them of their liberty to move freely in their chair. We consulted with both staff and a health professional as there were differing views as to whether the person could transfer safely without the presence of staff and whether this posed a health and safety risk. The restrictive practice of taking the wheelchair away from the person to protect their safety had not been authorised through a multi-disciplinary best interest meeting or included in their DoLS application and this was therefore a breach of Regulation 11 of the HSCA 2008 (RA) Regulations 2014.

At the previous inspection people had not had their capacity assessed or their deprivation of liberty safeguards authorisation (DoLS) updated to reflect a change of service. Since then staff had received basic awareness training of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what this meant for people in their care. The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. At this inspection staff were able to demonstrate through discussion their understanding of the need to assess for people's capacity to make decisions and choices for themselves, that where decisions needed to be

made by others this could be decided through best interest discussions which may also determine the need for DoLS to be applied for. On a day to day basis staff sought consent from people they supported around their care and support needs, and people were able to make clear when they were refusing any support and this was documented and respected by staff.
We spoke with a new permanent staff member who told us that they had undergone an induction to the service that included shadow shifts, orientation to the service and familiarising themselves with routines and peoples individual needs, reading policies and procedures and completion of a range of required basic training for example safeguarding, fire safety, first aid, food hygiene, infection control. Staff new to care were also registered to complete the care certificate but to date this had not been progressed and is an area for improvement. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

All new staff served a probationary period and attended probationary supervision meetings with a senior staff member to provide support and review progress. At the previous inspection we had highlighted that staff were unsupported without proper management oversight or access to regular one to one meeting opportunities with a senior member of staff. Since then staff told us that they felt better supported; that managers were present on a daily basis throughout the week and a deputy manager was also now in post. Staff confirmed that they had opportunities to meet with colleagues in staff meetings. They said they sometimes felt listened to but felt there remained a delay in some things they had asked for being progressed for example, behaviour strategies. This was because there had been a high number of incidents involving one person; these were closely analysed for trends and patterns by a behaviour therapist to help inform the development of a behaviour strategy. This had been made more difficult by the unpredictability of these incidents.

The behaviour therapist involved felt positive that incident plotting had shown a downward trend in some types of behaviours as the person became more settled. Staff still lacked some understanding and confidence in supporting the person because of the unpredictability of behaviour and had been left to work for a long time without clear support strategies for managing this.. Strategies had now been developed but at inspection were still to be shared with staff.

At the previous inspection we had raised concerns about staff awareness of people's food preferences and the lack of an established menu. At this inspection staff showed that they understood how to support people with special dietary needs and spoke about people's individual risks. For example, some people were at risk of choking and staff ensured that they used special cups, had thickened drinks and were provided with a soft diet. Staff said that they consulted people about their individual daily food choices and preferences but found too much information caused some people to become anxious, staff tried to respond to this by limiting the pictorial options they offered to two for each meal.

Staff consulted relatives and others who knew people well to understand peoples likes and dislikes to help build a picture of food preferences and inform the development of menus. Records of meals provided over the previous month showed that a range of preferred meals were offered but there was repetition on some weeks for example, Spaghetti Bolognese twice in one week and Shepherd's pie twice in another. We pointed this out to the locality manager as it was important that staff ensured there was not an overuse of peoples personal favourites and a more varied diet offered; this is an area for improvement.

Previous concerns regarding support around people's health needs had been addressed, everyone was registered with a GP on admission, health action plans were in place and updated, there was good evidence that appropriate referrals were being made to a range of health professionals and previous concerns

regarding the absence of an exercise programme for a physically disabled person had been progressed, weights were now routinely taken.

Requires Improvement

Is the service caring?

Our findings

One relative told us that they found staff were caring and approachable and kept them informed about what was happening with their family member. A health professional said that staff were able to provide them with an incredible amount of detail about the person they supported and knew them well.

People's privacy and dignity could be compromised, for example a hearing impaired person who had recently relocated within the building preferred their bedroom door kept open at all times, their immediate privacy was not compromised because the entrance to their room was an 'L' shape so they could not be seen immediately by staff from the bedroom door. There was however, no system in place to alert them to the presence of staff at the door should they wish to be private; we discussed this with the staff and manager present and have made a recommendation around this.

We recommend that the provider seek advice from a competent source regarding appropriate doorbell systems for hearing impaired people.

Staff were seen to be friendly, compassionate and showed patience in their interactions with people; they were attentive and responded appropriately to people's body language if this suggested they needed attention. They were using a PECS (Picture Exchange Communication System) board. PECS is an alternative communication aid used with people. This enabled the person to be kept informed about their activities schedule each day and when they would be going home to see their family. Staff were also enabling the person to have contact with their family through Skype video conferencing calls.

The atmosphere in the service was calm and relaxed and we also observed examples of kind and respectful exchanges between staff and people, with spontaneous affectionate interaction from staff towards people, for example talking softly and stroking a hand to offer reassurance and comfort.

Staff were supportive of visits from people's family members, and facilitated visits home for others. Relative's told us that communication from the locality manager and staff was good and they were always contacted about matters relating to the health and wellbeing of their family member, and any changes in care and treatment before these were implemented. They said they were asked to contribute their thoughts and felt listened to, we noted relative's corrections and comments on a care plan and the manager present said any suggested amendments would be considered and incorporated into the plan. Whilst there was not an expectation that people would move to less supported living from this service opportunities for skills development were provided for them to undertake domestic tasks suited to their level of skill and for which they had shown a particular preference and interest for example hoovering or helping with meal preparation; their activity schedule and goals ensured this level of skill and independence was maintained.

People's care plans contained information about the important people in their lives and important events they needed to be reminded about. Staff were familiar with their life stories, people's gender preferences around staff were respected and the staff rota reflected this.

Staff showed that they had an awareness people's individual styles of communication well enough to know their preferences and wishes and this enabled them to make active decisions about their everyday care and support. People were able to choose where they spent their time, for example, in their bedroom or the communal areas. Staff helped people to make decisions about what they wore, or did, where they ate and what they ate, and respected peoples choices about how they spent their time when at home and whether they wanted to participate in activities or to spend time in their room. Staff were observed asking people about what they wanted or seeking consent to provide support.

People's bedrooms were decorated and furnished to a good standard and they had their own televisions; they were encouraged with family or staff support to personalise their bedrooms with personal effects such as photographs, pictures, and small personal possessions, dvds, and televisions.

Requires Improvement

Is the service responsive?

Our findings

People were in good moods and there was a relaxed atmosphere. Relatives informed us that staff involved them in care plan development and sought advice around aspects of their family members care and support. They told us that they felt confident of raising concerns if they had any but always found the staff and managers approachable.

Health professionals confirmed that their support had been requested by the service and that a multi-disciplinary approach was now being arranged to discuss how to move forward with support to ensure all parties involved knew what each other were doing and there was a structured approach to the support offered by professionals.

At the last inspection we raised concerns about the pre-admission arrangements for new people and that this information had not been made available to help inform staff about the persons assessed needs. Since then the provider had made changes to ensure that new people considered for placement had a comprehensive assessment that involved staff also visiting the prospective resident and writing their own report of their findings, a period of transition was set up for a period suited to the pace of the person. Staff were provided with access to the pre-admission information and the placement of the prospective person was discussed with them.

For a recent admission however, we found that no protocol had been arranged to record a baseline weight for the person so subsequent weights could be taken against this and highlight weight gain or loss since admission and the possible reasons for this, similarly body maps were not recorded on admission to ensure the person did not have wounds, bruises, or other injuries pre-admission that might require further investigation and care. Health conditions and their impact and history had not been sufficiently explored to inform future support. These are areas for improvement to ensure peoples overall health is monitored and we discussed this with staff at inspection.

At the previous inspection we highlighted concerns that staff were working to care and support records from a previous placement. Since then a comprehensive care plan has been developed with the involvement of relatives that for example gave consent for photographs and information to be shared with relevant people, provided a brief profile and highlighted people that were important in the person's life, the care plan provided a communication passport and a copy of the vocabulary used by staff with them, it highlighted to staff what good and bad days looked like for the person and what they liked to do both in house and in the community. Daily routines were documented in great detail which ensured staff knew how to provide the support the person required but in accordance with their needs and wishes, this ensured staff knew what the person could do for themselves and what they needed support with. Previously we had raised concerns that the frequency of daily wellbeing checks for people were not being recorded and there was no assurance these were happening. Since the person was now more settled the decision had been taken that the frequency of these could be reduced, and staff confirmed they were now undertaking hourly checks unless people indicated they needed attention sooner.

An updated complaints policy and procedure were in place and since the last inspection the provider had ensured that the complaints procedure was displayed and had been developed into an easier read version. The Locality manager present at inspection recognised this would need to be revised further to meet the needs of people with very limited capacity and vocabulary and this was an area that advice would be sought from the behaviour therapist and speech and language staff which would possibly look at providing recognisable symbols that people would be familiar we have recommended this as an area for further improvement.

We recommend that the provider seek guidance from a competent source on the development of a suitable, appropriate and accessible complaints format for people with complex needs and very limited verbal skills.

At the last inspection we had raised concerns that people's interests, activities and personal preferences had not been developed and were not recorded either in their care plan or an activity schedule. Since then each person was provided with their own activity schedule and staffing was allocated to ensure there were sufficient staff to enable two to one support in the community. Whilst this was still in early stages of development for the person newly admitted, there was a detailed schedule in place for another person. This comprised of an outing into the community every day including weekends when for example they were supported to go shopping, bowling, to the cinema or dining out, in house preferred activities for example art and crafts or undertaking some preferred domestic tasks were also scheduled into the timetable. At least two car drivers were now rostered on every day shift to ensure this did not impact on planned external activities and transport was available for staff to use. There were also scheduled visits home at weekends.

Achievable goals were now being set to help people maintain or improve on their current level of skills and these were kept under review. Staff who were allocated as key workers to individual people told us that they produced a monthly report about the person they were responsible for, the locality manager currently responsible for updating peoples care plans regularly, spoke with each key worker individually about the person they supported, to understand what changes they had become aware of in the needs or support levels the person required. Relatives were also asked to review care plans for any changes they felt needed to be made. The care plan and associated risk assessments were then amended accordingly to reflect these changes. Each person had an annual review to which relatives and care managers were invited and this looked at whether the person's needs were continuing to be met at the service and whether additional support was needed to meet changing needs.

Requires Improvement

Is the service well-led?

Our findings

Feedback from relatives was that they thought communication was good and they were kept informed of their relative's wellbeing by staff. Staff said they felt better and more confident having manager's onsite more often and felt issues would be dealt with quicker.

At the time of the previous inspection and at this inspection the service remained without a registered manager despite an ongoing recruitment campaign by the provider. At the previous inspection interim management arrangements had been poor with support irregular and an absence of oversight by managers from within the organisation. At this inspection a schedule for management cover Monday to Friday each week had now been implemented and had been working for some months, management support days were divided between three separate managers, with clear on call and out of hour's management cover arrangements in place. Staff knew all of the managers helping with the day to day operational management of the service; they felt comfortable with them and able to talk with them if issues arose. Whilst there was not clearly defined areas of accountability arranged between the managers, some continuity was provided to staff in who they saw for supervision where possible seeing the same manager or managers so they could build a relationship and feel able to express themselves.

Quality monitoring systems were in place. These checked the quality of the service and care people received. At present owing to the active involvement of managers in the service no unannounced spot checks were undertaken, although the service was subject to a visit from the organisations compliance and regulation team which assessed service quality and identified areas for improvement. Some aspects of the current system of audits had not been utilised effectively as remaining shortfalls had not been identified for action to be taken. The locality manager undertook quarterly safety checklist monitoring, which looked at the safety risks and measures in place to keep people and staff safe and highlighted shortfalls to be addressed and monitored timescales for completion. However, this had not been effective in identifying that some staff were still to receive some specialist training for example practical moving and handling without which they could be placed at risk or at risk of harming people's safety.

Other audits conducted were a medicines audit, kitchen audit and infection control audit. The medicines audit needed expansion to take account of the improvement we have suggested and also the presence of protocols for administration of 'as required' medicines. The medicines audit was also not being undertaken to the frequencies suggested by the organisations own audit procedures. Whilst there had been improvements to the assessment, monitoring and supervision of the operational day to day management of the service, there was a failure to ensure that the audits implemented were utilised effectively and to the frequencies required by the organisation to identify shortfalls in practice and address these in a timely manner. This is a continued breach of Regulation 17 (2) (a-d) of the HSCA 2008 (RA) Regulations 2014.

Staff meetings were now being held regularly, these were recorded; we noted that whilst staff said they felt able to raise issues , minutes did not show that staff were actively involved in discussions and how their comments were acted upon; this is an area for improved recording.

A relative said staff were always talking with them so any views they had were made known to staff about different aspects of their relatives care, a system had been developed to seek stakeholder feedback, to analyse this and to feedback to people how their views had been used but this had not yet been implemented, work on how to gain feedback from people using the service was underway but not yet developed due to the complexities of peoples capacity and what form questions about their experiences would take. Health professionals said they had found staff honest and knowledgeable about the needs of people and the challenges they presented.

At this inspection we checked the actions that the provider had told us they were taking to address the previous and significant shortfalls. We were satisfied that the provider had taken appropriate action to address the majority of areas we had highlighted previously, but noted that progress in some areas was slower than expected. Learning from addressing these shortfalls had not always translated or been cascaded to other areas of the service to improve practice. For example, pre-admission still lacked fundamental basic checks around people's physical condition on arrival in regard to pressure areas, wounds and bruises, and weight on admission, assessing staff had not explored how mental health impacted on people, how it affected them on a day to day basis and the support they needed to high and low moods. Progress on Makaton training for staff had not been prioritised in respect of one person's needs and staff were therefore not confident in signing to them; as a result the person concerned who relied solely on their engagement with staff was at risk of becoming more isolated through the lack of interactive engagement from them.

A previous concern that staff were without computer logins to enable them to access appropriate policy, procedure information and documentation had been addressed, staff also confirmed they had been asked to read and sign they had read all policy and procedure information; new versions were also available within the office in hard copy for reference.

The atmosphere within the service on the day of our inspection was relaxed, open and inclusive, staff were seen to work in accordance to people's preferences and needs where their training had provided them with the skills to do so, their support was mostly discreet and unobtrusive.

Information about individual people was clear, person specific and readily available. Guidance was mostly in place to direct staff where needed. The language used within records reflected a positive and professional attitude towards the people supported.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Restrictive practice not authorised through a multi-disciplinary best interest meeting was in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was failure to identify and address new risks that had the potential to place people at risk of harm. Regulation 12 (2) (a). This is a continued breach of regulation. There were shortfalls in medicine management that could place people at risk. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure that the audits implemented were utilised effectively to identify shortfalls in practice and address these in a timely manner. Regulation 17 (2) (a-d). This is a continued breach of regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure all staff were provided with all the necessary training to

undertake their support of people safely and in accordance with their needs, and this is a continued breach of Regulation 18 (1) (2) (a). This is a continued breach of regulation.