Action for Care Limited

Willow View

Inspection Report

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Overall rating for this service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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Summary of findings

Overall summary

Willow View provides accommodation and personal care for six people with learning disabilities who live at the home. The service had a registered manager in place.

People told us they were happy living in the home, were safe and were provided with opportunities to undertake a range of activities. A relative and social care professional also told us this was the case

We saw people were involved in choices in relation to their daily lives for example choosing activities that they wanted to be involved in. More could have been done to involve people in their care plan review to ensure people were involved in the evaluation of their care package including their goals and objectives.

We found documentation required improvement in a number of areas. One person's care records did not contain the latest information on their needs as it had not been updated following a diagnosis of autism. Completion of other care records including those concerning people's health plans was also inconsistent with some documents missing. The overall records showing completion of staff supervision and appraisal were not clear so it was difficult to establish when staff had a supervision or appraisal. The problems we found breached Regulation 20, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Staff were aware of how to meet people's individual needs. Completion of training was mixed with some areas requiring improvement such as Mental Capacity Act (MCA) and manual handling to ensure staff we up-to-date with the latest available guidance and best practice.

Completion rates with other topics such a safeguarding and non-violent crisis intervention was better. The service had a workforce development plan in place to address shortfalls in specialist training such as autism. This meant that the service had plans in place develop staff skills in order to better meet people's individual needs over time.

We found staff had a good understanding of how to support people, their individual needs and how to keep them safe. We saw that staff had the time to forge meaningful relationships with people who used the service. Most people had one to one support, which allowed staff to develop close relationships with people. We saw staff provided kindness, compassion and companionship to people using a range of verbal and non-verbal communication techniques

Staff told us tht the management were open, supportive and fair and addressed concerns raised by staff and people who used the service. We saw that there was an established set of values and objectives which staff understood. An improvement plan was in place to ensure the organisation continuously improved the quality of its service and management were provided with support and resources to drive improvement. This meant that provider was able to continuously improve the quality of its services.

An incident reporting system was in place, but the lessons learnt from incidents were not always robustly documented which meant there was no record of learning from incidents which had occurred. The service's quality assurance systems had not identified and acted on deficiencies we found in care and staffing records.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People we spoke with told us they felt safe in the home and that staff respected them. A relative and social care professional also told us they were confident people in the home were kept safe.

The home had robust safeguarding and whistleblowing procedures in place and the staff were able to demonstrate they were aware of how to ensure concerns were acted on quickly to reduce the risk of harm to people. We looked at how a recent incident of aggression had been managed and staff and management were able to tell us of clear actions they had taken to prevent a re-occurrence. We saw evidence of their safeguarding incidents had been correctly reported to the Care Quality Commission (CQC) and Local Authority.

CQC monitored the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. We found one DoLS order was in place and staff understood the purpose of this and how to manage the restrictions to ensure the person's rights were protected.

Staff had a good understanding of the principles to follow to ensure decisions made were in people's best interests. Staff had a mixed understanding of the Mental Capacity Act (MCA), with not all staff able to confidently describe how it should be applied to ensure people's rights were protected.

Risk assessments were completed for significant risks to people who used the service to keep them safe. We found the provider had a positive approach to risk taking to ensure people were not overly restricted and giving people freedom and independence.

The home was clean and hygienic to ensure the wellbeing of people who used the service. There were infection control policies and procedures in place to ensure staff were clear as to their responsibilities with regards to cleaning and infection control.

Are services effective?

Staff had a good understanding of people's needs and wishes and interacted positively with people that used the service. People were supported to enable them to be as independent as possible.

People's health and support needs were assessed and care plans reflected their current needs. We found one case where care plans had not been updated with the latest information to enable staff to deliver appropriate care.

Summary of findings

Care plans included people's views and wishes and it was evident they had been asked for their choices with regards to their preferences in relation to their daily lives. However there was a lack of evidence that people were involved in their care plan review to evaluate the success of their care package and their goals and objectives.

The completion of health action plans required improvement as key sections were missing. Health action plans detail the actions that are required by each person with a learning difficulty, to maintain and improve their health and any help that might be needed to accomplish this. The use of the hospital passport system was inconsistent with two people not having one in place. A hospital passport is used in the event of a hospital admission to ensure hospitals have relevant information on people's needs and preferences, especially when people cannot speak for themselves. The lack of hospital passports meant that hospitals may not have been able to provide individual care to meet these people's needs as sufficient information was not present.

The service had a workforce development plan which planned the training and development priorities for staff over the next year. We saw that the completion of staff training was mixed with most staff up-to-date with safeguarding and non-violent intervention training but completion of other learning such as infection control and manual handling required improvement. The records for staff supervision and appraisal required improvement as it was unclear when staff last had a supervision or appraisal.

Are services caring?

We spoke with four people about how they felt about the care they received. People were positive and said they received good care. All four people commented that staff were friendly, for example one person told us "the staff are great and I have a laugh with them."

We observed care and saw staff had the time to forge meaningful relationships with people who used the service. For example we saw one staff member reading stories to a person for most of the afternoon. As most people were receiving one to one support, this allowed staff to develop close relationships with people.

We asked staff about people's individual needs and preferences and found staff had a good understanding about each of the people we asked them about. This meant people received care from people that were familiar with them and their needs.

People's dignity and diversity was respected. We saw staff knocked on people's doors before entering and ensuring dignity was maintained when providing personal care.

Summary of findings

People told us that they felt staff listened to them and valued their opinions and choices. We saw that resident meetings were held, and people's views recorded.

Are services responsive to people's needs?

People were supported to express their views about their daily living and there was evidence these choices were recorded. We saw some good interactions between people who used the service and it was clear people were given the time to make decisions. We found more could be done to involve people in the creation and review of care plans and risk assessments.

People's capacity was considered when decisions needed to be made and advocacy support provided when necessary to support and enable people to air their views. This helped ensure people's rights were protected when decisions needed to be made.

Individual needs were assessed and met through the development of personalised care plans and risk assessments. Care plans considered people's social life which included measures to protect people from social isolation. There were enough staff to provide a good level of interaction.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time. There had been no recent complaints received by the service, but our discussions with people who used the service, staff and service users gave us assurance they would be dealt with appropriately.

Are services well-led?

Staff and people who used the service spoke positively about the managers who worked at the home and said they were open and honest and listened to them.

Incidents were reported and analysed and investigations took place where appropriate. There were no documented lessons learnt regarding incidents that took place and no overall analysis of incidents of restraint. This meant that the organisation may have missed opportunities to learn from incidents.

We found that quality assurance systems had not identified the inconstancies in completion and update of care plan documentation as identified within the "Is the service effective" section" of this report. This meant these systems required improvement to ensure all risks to the service were identified.

Summary of findings

A service improvement plan was in place which clearly detailed how the service was to achieve improvement over the next year, for example in developing specialist staff skills. The actions on this plan matched with what the deputy manager told us were the main priorities for the service.

Systems were in place to ensure an appropriate level of staff with the correct skills were present to support people in order that their individual needs were met.

Systems were in place to monitor the service and identify any emerging risks. The management were provided with suitable high level support from senior management to develop and drive improvement.

Summary of findings

What people who use the service and those that matter to them say

We spoke with four people who used the service. Their comments included:

”Amazing, great people. When I feel let down they are here to help. I feel safe in their company.”

“The place is kept properly clean.”

“I can do anything I want.”

“I feel safe.”

“It’s more friendly here.”

“The staff are great and I have a laugh with them.”

“I can play on my X-box when I get bored.”

“I play Bingo, go swimming and go to the pub.”

A relative of a person who use the service told us:

“People are really well treated, like home from home.”

They involve me and call me if there are any issues.”

“Staff are brilliant.”

“They are responsive to health needs; they get medical advice when appropriate.”

Willow View

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Willow View is a small residential home for people with learning disabilities. It is operated by Action for Care Limited. The home is registered to accommodate up to six people. On the day of the inspection there were six people living at the home.

We visited the service on 3 April 2014. We used a number of different methods to help us understand the experiences of people who used the service, including talking with people, observing the care and support being delivered and looking at documents and records that related to peoples support and care and the management of the service.

The inspection team consisted of a Lead Inspector and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience gathered information from people who used the service by speaking with them in detail. The Expert by Experience was supported by their support worker.

Before our inspection, we reviewed all the information we held about the service and contacted the local authority.

On the day of our inspection, we spoke with four people who used the service, one relative, one social care professional and four members of staff.

At the last inspection in April 2013 the service met all the national standards that we looked at.

Are services safe?

Our findings

Four people who used the service all told us they felt safe in the home and staff were friendly towards them. For example one person told us "I feel safe in their company."

A relative of a person who used the service and a social care professional involved in the care of a person who used the service both told us they thought the service was safe and they had no concerns regarding the safety of the people they knew who used the service.

Staff had a good understanding of what constituted abuse and they were all able to tell us confidently of how they would escalate any concerns. They all told us they had received safeguarding training and the training records we looked at confirmed this was the case. Staff told us that the manager and deputy manager were good at addressing any concerns raised and they were confident safeguarding issues were fully investigated.

We asked the deputy manager about recent safeguarding incidents. They told us one had been reported to the Local Authority safeguarding unit in 2014. This matched with the number of incidents reported to the CQC. We looked at this incident and saw evidence this had been reported on the providers incident form and reviewed by the manager. The deputy manager was able to tell us about the actions they had taken to prevent a re-occurrence of the incident.

We saw safeguarding policies, procedures and flow charts were available to staff as well as whistleblowing policies which supported staff in raising concerns.

The deputy manager told us that restraint was occasionally used by staff, this was always documented and staff had received appropriate training. We looked at the providers training matrix which confirmed staff had received training in non-violent crisis intervention techniques.

We spoke to the manager about challenging behaviour in the home and they were able to describe to us people's triggers, aggressive tendencies and how they reduced the risk to people. Staff were confident in dealing with challenging behaviour and was able to tell us strategies for calming people down.

The deputy manager told us that all incidents and the use of restraint were recorded on incident forms in people's files and then collated centrally each month by the manager. We looked in three people's records and saw evidence incident forms had been completed following incidents and the use of restraint to ensure the service was monitoring the use of restraint.

In one person's care records we found an incident had occurred in March 2014 where a person had injured their head and NHS Direct were called for advice. Although this was described in the daily notes, it had not been reported on an incident form. We raised this with the deputy manager who agreed that it should have been reported.

We asked the manager about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and they were able to describe to us the procedure they would follow to ensure people's rights were protected. Where people did not have capacity to make complex decisions, the manager was able to give us examples of where best interest meetings were held involving advocates and other health and social care professionals. We saw a DoLS order was in place for one person who used the service and the manager and staff understood why the restrictions were in place and what the conditions were in order to protect the person's rights.

We found staff had a good understanding of the principals to follow to ensure decisions made were in people's best interests. There was mixed understanding of the specific requirements of the (MCA). We looked at the staff training matrix and found only four staff had completed training on the MCA. One staff member told us they had not received any training on MCA but felt this would be beneficial in order to better understand the requirements of the act.

Staff were able to describe how they ensured individual needs were met. This included using signs and body language to ensure people's views were taken into account. All people in the home received at least one to one support and this allowed good relationships to develop. It was clear speaking with staff that they understood how to ensure each person was kept safe.

We saw the provider had a risk management policy in place which detailed the need to ensure risk assessments were carried out where risks to people were identified. The policy focussed on ensuring that people's individual freedoms and choices were protected. We saw evidence of this philosophy in the risk assessments we viewed. Risk assessments with risk ratings and control measures were in place, managing people's behaviour and how to support

Are services safe?

them. For example in the use of knives in cooking. Risk assessments were in place for a range of foreseeable risks to people who used the service with clear control measures.

We spoke with one person who used the service about how they felt the service managed their risks. They told us that they thought the balance was right and they were monitored for their own safety especially when they were feeling low but that this worked well. They told us staff were enabling and let them do everything they wanted to. Another two people were happy with the balance of support and independence offered by the service with bathing and hygiene.

The manager was able to give us examples of positive risk taking. For example one person had posed a risk when they went out in the community; however the service had not prevented them from going out and had instead reviewed risk assessments and ensured a greater level of staff support was provided. This demonstrated that risks were well managed and people's freedom not overly restricted.

We found the provider had an infection control policy in place which described the key responsibilities within the service. Staff were able to describe to us when they would wear Personal Protective Equipment (PPE) such as and correct hand washing techniques.

Infection control documentation was in place which included audits, legionella risk assessments and cleaning schedules which showed the required checks and cleaning was undertaken. The deputy manager told us that staff undertook the cleaning in the home. The manager told us some people were also encouraged to assist with the cleaning, particularly in their room to increase independence in this area.

We looked around the home and found it to be a clean and pleasant environment with no offensive odours.

Are services effective?

(for example, treatment is effective)

Our findings

We looked in three people's care records. Care plans reflected people's current needs. For example information was present to support people with personal care, physical health, mental health, communication, behaviour, mobility and social skills. Information contained in the care plans was personalised and it was clear that people's specific needs and preferences had been obtained through getting to know their individuals likes, dislikes and behaviours. There was evidence choices had been recorded such as where people liked to spend time, the activities they liked to be involved in and where they had refused tasks such as help with hygiene.

The level of involvement people had in the assessment of their needs was not always clear. The care plans we looked at were not signed by the person or a relative/advocate. The deputy manager said those with capacity were often not interested in reviewing their care plans. We felt the service could use more innovative ways to promote involvement in care planning. Although care plans were relatively detailed, they were not written in a format that would best engage with people who used the service, for example they were completely text based. There was no about me or likes/dislikes section to the care plans which people who used the service could have directly contributed to/or written themselves. There was no section which provided people with information on their medicines in an understandable format. We asked one staff member about person centred plans and they did not know what they were.

The staff and management we spoke with all told us that increasing people's independence was a key aim of the organisation. All the staff we spoke with thought that the people they supported had developed and achieved a greater level of independence whilst living in the home. Care plans contained short and long term goals which described how this would be achieved for example through developing social skills.

In one person's care file, we saw they had been diagnosed with autism in September 2013, but although their care plans such as mental health, behaviour and social skills had been recently updated, the diagnosis and recommendations from the psychiatrist had not been considered in the care plan updates. This meant the care plans did not contain accurate information on this person's current needs and any additional information needed to support someone living with autism such as a sensory profile.

We saw evidence that people had access to independent advocacy services when important decisions needed to be made. The deputy manager was able to give us examples of when advocates had been used and who was currently using an advocate to speak on their behalf.

We saw evidence each person had a healthcare file which recorded all visits with health professionals such as GP's and community staff. These included advice which staff could refer to. We looked in people's care files and saw they had been referred appropriately, for example one person had been referred to a psychiatrist following concerns over their behaviour and had received a diagnosis of autism. Each person who used the service had a physical health needs care plan which provided staff with information on managing people's health needs, however the completion of health action plans required improvement. In two cases, we saw people who used the service had started completing health action plans with assistance from staff. The deputy manager told us a third person's had been destroyed accidently by the person. The health action plans contained people's health aims, and the date of their next annual health check-up, however several sections had not been completed including the action plan section. This meant there were no details of the actions and target dates needed to improve or maintain the health of the people.

We found the use of a hospital passport system was inconsistent. A hospital passport is used in the event of a hospital admission to ensure hospitals have relevant information on people's needs and preferences, especially when people cannot speak for themselves. In one person's records they had a hospital passport which contained details of their needs should they be admitted to hospital. However the other two people who we looked at did not have one in place as the documentation had not been completed.

The problems we found breached Regulation 20, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report

Are services effective?

(for example, treatment is effective)

Staff had a good understanding of people's needs, preferences and choices, for example telling us what people liked to eat, where they liked to sit and spend time. Staff were able to tell us about people's health and behavioural needs and how they met them.

We observed care in the home. Staff were observed reading, talking, looking at pictures and listening to music with service users. Staff understood the people who used the service and their individual needs. Most people looked happy, for example one person laughed regularly throughout the visit, although one person told us they were upset as they had difficulties in seeing their family. We raised this with the manager who was able to clearly describe the action they were taking to support this person to have regular contact with their family.

We spoke with staff about training and support. Staff told us that they thought they received effective support, induction, supervision and training and were confident in their ability to carry out their role. Staff told us they had been supported to undertake national qualifications in care.

We found completion of the training programme was mixed. We spoke with the training lead who confirmed the training matrix was up-to-date. It showed that all staff had completed non-violent crisis intervention training and most staff were up-to-date with safeguarding. In other mandatory topics such as health and safety, food hygiene, infection control and fire, equality and diversity, manual handling, and Mental Capacity Act, less than 50% of staff had completed training. We spoke with the deputy manager about this who confirmed they were currently requesting staff to work through the training to ensure a better completion rate.

There was no provision on the training matrix for any specialist training such as mental health, epilepsy and autism despite service users in the home having autism, epilepsy and mental health problems. The deputy manager told us some staff had received training in autism and epilepsy, but it was yet to be formalised onto the annual training programme. They told us that the service was working to ensure specialist training was provided in a more structured way. We saw examples on the service improvement plan that developing expertise in a number of areas such as autism and diet and nutrition was a priority. For example developing expertise in autism was planned through the autism accreditation scheme managed by the National Autistic Society.

The deputy manager told us how they had recently appointed champions in a number of areas such as dignity and respect, autism and nutrition and that these staff would be promoting these areas within the service and ensuring specialist help and expertise was available. The manager told us this would be done in conjunction with other services that the provider to ensure expertise was shared. The service improvement plan confirmed to us that this was a priority.

We looked at the staff supervision and appraisal matrix. The manager told us that supervisions were held every three months and appraisals annually. We found some gaps on the matrix which made it difficult to confirm when some people had last received a supervision or appraisal as the records were not clear. There was no evidence of any supervision since September 2013 which meant staff had not recently been involved in a formal review of their performance, aims, objectives and any issues arisen in relation to the care provided.

We saw evidence the management team had put in place a workforce development plan which aimed to develop and improve the skills of staff. This included an evaluation of sickness and employee turnover. Priorities included making sure staff attained a recognised qualification in health and social care and the rolling out of specialist training such as autism. The plan showed that 13 members of staff out of 20 had already attained a level two qualification and five have attained a level three qualification.

Are services caring?

Our findings

We spoke with four people about how they felt about the care they received. People were positive and said they received good care. For example one person told us ""Amazing, great people. When I feel let down they are here to help." Everyone commented that staff were friendly. One person who used the service told us they felt the service had got the balance right between giving them privacy, independence and offering them support.

We spoke with a relative of a person who used the service. They told us their relative was really well treated in the home; staff respected their preferences and always showed dignity and respect. A relative told us "People are really well treated, like home from home."

A social care professional who visited the home also told us staff and management at the home were caring and showed kindness and compassion to people who used the service.

We observed care and saw that staff had the time to forge meaningful relationships with people who used the service. Most people had one to one support, which allowed staff to develop close relationships with people. During the inspection we saw staff provided kindness, compassion and companionship to people using a range of verbal and non-verbal communication techniques. Staff were genuinely interested in people and made sure they were occupied and happy. People looked happy and smiled and laughed in response to staff interaction.

We asked staff about people's individual needs and preferences and found staff had a good understanding about each person's care needs that we asked them about.

We saw staff knocked on people's doors before entering rooms and ensured dignity was maintained when providing personal care. Staff provided us with examples of how they ensured people's dignity and privacy was maintained. Staff also recognised the importance of ensuring people's independence was increased and life skills were developed and were able to give us good examples of how this had been achieved.

The manager told us how the service had recently appointed a dignity champion and they were responsible for promoting dignity amongst other staff and challenging any poor practice. This would raise awareness regarding dignity and respect within the service.

One person who we spoke with and a relative told us that they were confident that they were listened to and that their views were taken into account. The manager told us resident meetings took place monthly, we saw evidence meetings took place in October 2013 and January 2014 however the deputy manager told us it was sometimes difficult to attract residents to the meetings and that is why they had not always taken place monthly. We looked at the minutes from the most recent meeting in January 2014 which confirmed that people's views had been recorded. We asked the manager about a couple of the issues raised and they confirmed action had been taken to ensure people's views were acted on.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People said they were encouraged to make their views known regarding care through the planning of their daily lives. One person told us they could do whatever they wanted to and staff had encouraged them to try a range of activities.

One relative told us they were fully involved in the care provided and the provider always contacted them to discuss any issues. They also told us "They are responsive to health needs; they get medical advice when appropriate." A social care professional who was involved in the care of people living at the home told us that the service encouraged people to take control of their daily lives.

We found that people were supported to express their views and make decisions about daily living. For example, we saw people who used the service were actively involved in creating a weekly activities plan based around their views and preferences for the week ahead. We saw evidence people got to air their views in relation to the weekly choice of meals. Through speaking with staff and people who used the service we felt confident that people's views were taken into account.

We observed some good interactions between people who used the service and it was clear people were given the time to make decisions. For example one person had difficulty communicating verbally. We saw that staff were patient and repeated words back to the person to ensure that the interpretation was correct. We saw staff were responsive to people's needs, asking them questions about what they wanted to do and planning future activities. Staff were patient with people, valued them as individuals and listened to their responses.

The deputy manager was able to provide us with examples of how care and support was provided in accordance with people's preferences and what was important to them. For example they showed us how one person wanted to lose weight so they had created a healthy living plan with them. This person confirmed to us that the service had assisted them to eat healthily.

We looked at three care plans. We found people had their individual needs regularly assessed and met. We saw evidence care plans were regularly reviewed and additional information was regularly added regarding people's care and support. A range of assessments were in place which provided staff information on how to support people. Specialist assessments were in place where people had specific risks such as epilepsy. There was no evidence that people had been actively involved in the development or review of the care plans and their longer term goals and objectives. This meant people may not have understood or been aware of their care and support plans, options available, or have had a say in their long term plans.

We looked at people's daily records which contained information on people's behaviour and mood and the support they had received each day. The deputy manager told us that the three daily handovers were a vital arrangement in order to ensure information was passed on to ensure people had their needs met. Staff confirmed to us that handover was usually very detailed and gave them good information about people's needs. We saw documentation which confirmed these took place.

We saw evidence that mental capacity assessments were completed where the service considered a person may lack capacity to make a decision. We spoke with the deputy manager who was able to give us several examples and show us documentation where people's capacity had been assessed. We saw evidence where people did not have capacity, best interest meetings had been held. The deputy manager told us about the advocacy services that were available to people who used the service.

Staff timetables were based around supporting people on a one to one basis. We saw evidence the service had a flexible approach to ensuring people could undertake the activities they wanted to on a particular day. This included regularly going out into the community as well as undertaking activities in the home. We looked at daily records and saw people had been supported to undertake a range of bespoke activities which included, rides out in the car, baking and arts and crafts. A relative confirmed there was a wide range of activities available.

Care plans considered social isolation and each care plan had a social needs section which ensured people were provided with an appropriate level of social interaction. The staff we spoke with had a good understanding of people's individual social needs. As most people received one to one support, we found staff regularly interacting with people to provide companionship and prevent them becoming lonely.

Are services well-led?

Our findings

We asked people who used the service about the management at the home. One person told us the home manager was "excellent and funny." Another person said they were the "captain of the ship". Most people said the manager was usually visible.

We spoke with three staff who all praised the culture in the organisation and said the management were supportive, fair and open. They told us that if they went to the manager with an issue it would be effectively resolved. Staff told us they were sure issues raised would be dealt with sensitively and confidentially. The deputy manager said the manager at the home had an open door policy. Staff confirmed this to us and said management were approachable and they felt able to talk with them about any aspect of their role and any concerns they had.

We asked staff and the deputy manager about the values and aims and objectives of the service. Staff provided reasonably consistent messages about the values of the organisation, which focused on ensuring people received a good quality of life, ensuring equal opportunities and promoting independence. We found this was consistent with terminology used in policy documentation, job specifications and in people's daily records and care plans.

We asked the deputy manager how people were involved in the running of the service. They told us that people who used the service were involved in the recruitment process in order to make sure the staff who supported them were suitable. We also saw evidence that people were involved in decisions regarding the running of the service through residents meetings, although meetings were not always held monthly as was the aim. They told us at present people were not involved in the review of the service's policies, procedures or documentation such as care plan format. There was currently no provision for people who used the service to be involved in the supervision or appraisal process for staff which meant that people who used the service did not have a say in the evaluation of the performance of staff.

We saw evidence that staff meetings were held and the minutes showed us staff were encouraged to air their views in relation to the service. We saw evidence that discussions had taken place on each person who used the service to evaluate the service provision. Evaluation of staffing levels had also taken place at the last meeting. We also saw evidence that monthly management meetings were held where higher level issues were discussed.

We asked the deputy manager about systems in place to ensure concerns and complaints are dealt with appropriately. They told us they had not received any complaints in the last two years but were able to confidently describe appropriately how complaints would be dealt with. Information was present in an easy read format to support people in bringing their complaints to the attention of people who used the service. We saw incident and accident data was collated each month by the manager although there was no evidence of any analysis for lessons learnt following each incident.

We saw the provider had in place a complaints policy, and whistleblowing policies detailing how people and staff could raise complaints. In addition the complaints policy was in an easy read format for people who used the service. We asked people who used the service about how to raise a complaints and they were able to tell us they would go to their keyworker or deputy manager to raise issues. No concerns about the service had come to the attention of the Care Quality Commission.

We saw evidence the provider had a service improvement plan in place which detailed how it was to continuously improve the quality of the services provided. This included developing a greater level of expertise in areas such as dignity and nutrition through the staff champion programme and working towards accreditation for autism. The areas for development on the plan matched with what the deputy manager told us were the services priorities on the day of the inspection.

A senior manager explained how they supported the manager with service improvement through monthly site visits. We saw a report from a recent site visit in March 2014 which discussed how the service was going to address issues found or raised during the visit. This included staff training and improving the environment in the home.

We found an incident management system was in place to enable staff to report incidents. Although incident forms were completed and there was evidence they had been reviewed by a manager, there was no section which described in adequate detail the action taken following each incident to ensure lessons were learnt. For example

Are services well-led?

an incident which occurred in January stated “mental health deteriorating “as the trigger to the incident. Although the deputy manager was able to confidently describe to us the measures taken to prevent a re-occurrence this was not recorded, which increased the risk that the organisation did not learn from the incident.

We saw evidence a monthly operations report was completed by the manager detailing any meetings, complaints, incidents and key risks which had emerged. There was no provision on the form to collate or analyse the number of physical restraints that had been undertaken by staff each month. This was submitted to head office.

The completion of care plan documentation was inconsistent as discussed within the “Is this service effective?” section of the report. There was no evidence that these inconsistencies had been identified by management through quality assurance systems such as care plan audits.

We asked the deputy manager how staffing levels were calculated in the home. We were shown documentation which showed the allocation of staff members against each service user. This took into account their individual dependency level. This meant the rota was planned so that each staff member knew exactly who they would be working with and so the service could plan appropriate staffing resources. The manager told us all staff had the opportunity to work with all six people who used the service and as they only supported six people, staff had gained the knowledge to understand their individual needs. The manager was able to give us examples how they had reviewed the staffing levels in response to incidents to ensure people were provided with more support if necessary. For example we saw evidence which confirmed this that showed a person now had two members of staff when they went out into the community.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010, Records. An accurate record in respect of each service user which shall include appropriate information and documents in relation to the care provided was not maintained. Other records relating to management of the regulated activity were not always maintained