Kingston upon Hull City Council

Kingston upon Hull City Council - 220 Preston Road

Inspection report

220 Preston Road
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 February and 1 March 2018 and was unannounced on the first day. At the last inspection in November 2015, the provider was compliant with regulations in all areas we assessed.

220 Preston Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

220 Preston Road accommodates up to 10 young adults who have a learning disability and autism. The service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. The service has two floors accessed by stairs and is divided into two separate areas with five single bedrooms, a bathroom, a shower room, a sitting room and dining room in each one.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some areas of the environment posed a potential risk to people. These included damaged items of furniture, a leaking toilet, some cleanliness issues and low temperature of the hot water outlets. You can see what action we told the provider to take at the back of the full version of the report.

People who used the service had an assessment of their needs, risk assessments and a care plan. There was an inconsistency in the care files with some people having good, informative care plans for specific areas whilst other had basic plans, which lacked update. We have made a recommendation about reviewing the care files to address shortfalls.

There was a quality monitoring system in place, which consisted of audits, checks, surveys and meetings. We found some shortfalls in the auditing of the environment and addressing issues in a timely way. The registered manager told us they would monitor cleaning schedules more thoroughly and ensure shortfalls were addressed quickly.

Staff knew how to safeguard people from the risk of harm and abuse. They had completed training and knew how to raise concerns.

Staff had been recruited safely. There were sufficient numbers of staff on duty at all times, and with an appropriate skill mix, to meet people's assessed needs. Staff had access to induction, training, supervision and support, which enabled them to feel skilled when supporting people who used the service. Additional

training had been delivered to the staff to equip them with skills and approaches when supporting one person with anxious and distressed behaviour.

We observed staff had a kind and caring approach. They knew people's needs very well and supported them to maintain independence, privacy and dignity. Staff also supported people to make their own decisions as much as possible in order to maintain their human rights. They ensured that when people lacked capacity, they included relevant people in best interest decision-making.

Medicines were stored safely and administered to people as prescribed. There was a shortfall in stock control, which had led to avoidable wastage of some medicines. This was mentioned to the registered manager to address.

People's health care needs were met and they had access to community health care professionals when required. The registered manager and staff team had developed good working relationships with health colleagues. This had resulted in planned discussions about treatment options and had been supportive of people who used the service when they required treatment.

People's nutritional needs were met. Menus provided them with choices and alternatives. Staff contacted dieticians and speech and language therapists in a timely way when they had concerns.

There was a range of meaningful occupations and activities for people to participate in and planned visits to local facilities were completed.

The provider had a complaints policy and procedure and staff knew how to manage complaints. Relatives told us they felt able to raise concerns if required. All three relatives spoken with described an open culture and accessible management. They were happy with the service their family member received.

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 consistently safe.

There were parts of the environment that posed a potential risk to people. There were also some cleanliness issues that required addressing.

People received their medicines as prescribed. Stock control had led to avoidable wastage of some medicines.

Staff knew how to safeguard people from the risk of abuse and where to raise concerns when required.

There was a robust staff recruitment process and sufficient numbers of staff employed to meet people's needs.

Is the service effective?

Good

The service was effective.

People were supported to make their own choices and decisions as far as possible. When people were assessed as lacking capacity, the provider acted with mental capacity legislation and involved relevant people in decision-making.

People's health and nutritional needs were met. They received input from community health care professionals when required. The meals provided offered choices and alternatives.

Staff received induction, training, supervision and appraisal to ensure they felt confident supporting people who used the service.

Is the service caring?

Good

The service was caring.

We observed staff had a kind and caring approach, both in interactions with people and when talking about them to inspectors.

Staff supported people to maintain their independence as much

as possible and promoted privacy and dignity.

Staff used various tools to help make communication and information accessible to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had assessments, care plans and risk assessments in place. There was an inconsistency in the quality of these documents and more work is required to ensure they include up to date guidance for staff.

People had access to meaningful occupations and activities. These included those arranged in the service and those accessed, with staff support, in the local community.

The provider had a complaints procedure and relatives said they felt able to raise concerns. We were unable to locate an easy-read version of the complaints procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although there was a quality monitoring system, the environmental audit had not been sufficiently robust to identify risks, cleanliness and areas to address. When issues had been identified, there had been a delay in addressing them.

The culture within the organisation and in the service was described as open and honest. The registered manager had developed close working relationships with the staff team and other health and social care professionals.

Staff told us they felt supported by management and worked well as a team.

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Detailed findings

Background to this inspection

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

This inspection took place on 28 February and 1 March 2018 and was unannounced on the first day. The team consisted of two adult social care inspectors

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with local authority safeguarding team and contracts and commissioning teams.

During the inspection, 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 how staff interacted with people who used the service throughout the day and at lunchtime. We spoke with three relatives of people who used the service. We spoke with the registered manager, the deputy manager, two care leaders and four care workers. Following the inspection, we received information from two health professionals.

We looked at four care files, which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) for all10

people and monitoring charts when people had anxious or distressed behaviour. We looked at how the service used the Mental Capacity Act 2005. This was to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

We found there were some areas of the environment, which were a potential risk to people who used the service. These included sharp splinters of wood in a window frame in a shower room and the same in a chest of drawers in one of the lounges. Plastic gloves were accessible in showers and bathrooms, which posed a risk of ingestion. There was a wet floor in an upstairs toilet, which was due to a leak. There was a sharp twisted piece of metal on a door handle in a shower room and a sharp television aerial point hanging from the wire in a bedroom. Two sinks used by staff had very hot water and required warning signs to alert them. A bolted lock on the outside of one person's bedroom was immediately removed.

There were some areas of the service that required cleaning. These included the sensory room floor and doorway, windows throughout the service and stairwells. Items in one shower room used for collecting urine samples required disinfecting or discarding. The sensory room was cold and cluttered with items on the floor behind a chair. There was no system for cleaning the plastic floor mats and other items. We highlighted all these risk areas to the registered manager who arranged for them to be made safe by the next day.

Staff had completed training in infection prevention and control. We saw there was personal, protective equipment for staff to use such as gloves, aprons, hand gel, liquid soap and paper towels. The laundry had a commercial washing machine capable of a sluice wash function for soiled linen, which helped to prevent the spread of infection. We saw the washing machine had stalled mid-cycle and was showing a fault. The registered manager told us they had a contract with a local firm for repairs and would contact them straight away. A risk assessment for legionella had been completed and the temperature of stored hot water was monitored to ensure this remained at an appropriate level. The hot water temperatures in all the bedrooms were below the required temperature and most of the bedroom taps had a low water pressure, which meant it came out in a trickle or not at all; this had been identified on previous audits. A plumber attended the service on day two of the inspection to descale the taps and check the thermostatic monitoring valves.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

Staff knew how to safeguard people from the risk of harm and abuse. In discussions, they were knowledgeable about the different types of abuse and the signs and symptom that would alert them to concerns; they knew how to report incidents of abuse or poor practice. There were systems in place to manage people's personal allowances to minimise the risk of financial abuse. We observed staff interactions with people and these were completed in a kind and patient way. Relatives told us they felt safe leaving their family member in the care of the staff team. Comments included, "He seems very happy there", "She is very supported and they are kind to her" and "When he visits, he is happy to go back."

There were risk assessments for specific people with regards to health issues such as epilepsy management, falls and weight loss. Staff had also developed risk assessments for areas such as anxious or distressed behaviour, use of the minibus, swimming and visits to community facilities. The provider had arranged intensive training sessions for staff to ensure they were able to support one person whose behaviour was

challenging to other people who used the service and staff. Staff had been provided with specific equipment to protect their arms from scratches when the person they supported was anxious or distressed. In discussions, staff were clear about how to support the person and keep other people safe. Comments from staff included, "We had 'Team Teach' for four days which included de-escalation, holding techniques and role play; it helped us to deal with behavioural issues." Staff explained how they had a two-day 'Team Teach' course to develop a management plan for one specific person in order for staff to provide consistent support to them. They also provided descriptions of how they put management plans into action to protect specific people.

Accidents and incidents were recorded so that learning could take place. There was reflective practice for staff to help prevent reoccurrences.

We saw medicines were managed safely and people received them as prescribed. There was a policy and procedure held with people's medication administration records (MARs), although we saw this did not include reference to covert administration if required. We mentioned this to the registered manager to address. There was guidance for staff when people were prescribed medicines on an 'as and when required (PRN) basis' and plans in place for the use of rescue medicines for epilepsy. We observed staff administering medicines to people and this was completed in a patient and safe way. We saw people were not over-medicated and only received PRN medicines when they were actually required.

There were some minor recording issues, which were mentioned to the registered manager to address such as when medicines were received into the service. There was also a stock control issue for some medicines, which had led to avoidable wastage. The registered manager assured us these would be addressed.

There were sufficient staff on duty to meet people's assessed needs. There was a good skill mix in the staff team; this consisted of the registered manager, deputy manager, care leaders, care workers and activity co-ordinators. Ancillary staff were in place for domestic, catering and administration tasks, which enabled care staff to focus on their caring and support role. The registered manager had access to maintenance personnel and could place requests for actions when required. A health professional said, "There always appears to be sufficient staff."

The staff recruitment process was robust and included employment checks prior to staff starting work in the service. These included an application form to assess gaps in employment, two references, an interview and a Disclosure and Barring Service (DBS) check. DBS checks helped employers make safer recruitment decisions and included a police check.

The provider had a business continuity plan for specific issues such as flooding and failure of utilities. The plan included emergency numbers for staff. Equipment used in the service such as portable electric appliances, fire-fighting items and emergency lighting were serviced regularly. The registered manager checked the emergency call system and held fire drills to make sure staff were aware of actions to take in emergency situations. All people who used the service had a personal plan which identified the specific assistance they would need from staff should emergency evacuation of the building be required.

Good

Is the service effective?

Our findings

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager had made applications to the local authority for DoLS for all nine of the people who used the service. Six were authorised and the remaining three applications were awaiting assessment. This showed us the registered manager was aware of the criteria for DoLS and had acted appropriately.

Staff had completed MCA/DoLS training and were aware of their legal responsibilities. We saw capacity assessments and best interest decision forms had been completed for specific issues. We saw there were two instances when best interest decisions had not been recorded and these were mentioned to the registered manager to update paperwork or obtain the information from other health care professionals. In discussions, staff had a good understanding of the need to obtain consent prior to care tasks. Comments included, "We ask for cooperation with tasks and people are willing. If they decline support, we don't persist", "We ask people who can tell us what they want. One person can write things down" and "If people don't have capacity then we have to have best interest meetings, for example with health interventions."

People's health care needs were met and they had access to a range of community health care professionals when required. We saw referrals to the health care professionals were made in a timely way and staff recorded and followed advice and instructions from them. A relative confirmed this and said, "They get the doctor or community nurses if there are any problems." We could not locate any health action plans. These were used to collate information about people's health care needs so these could be monitored closely in a structured way and in an easy read format. However, comments from health care professionals involved in people's care included, "We work closely with 220 [the service] to address current health needs and advice is sought from the dietician." The registered manager told us they would seek advice about health action plans from the local community learning disability nurses.

People's nutritional needs were met. People's weight was monitored and there were referrals to dieticians and speech and language therapists for advice and treatment when required. Each person had a plan of care and their profile highlighted likes and dislikes. Catering staff received information about likes and dislikes and any special dietary needs; menus provided choices and alternatives. The menus reflected the choices younger people would make, with hot and cold choices at each meal and there were treats such as takeaways built into the meal plan. We observed the lunchtime experience for people in one side of the service; this could have been organised in a more effective way to ensure those people who required more

support had this consistently throughout the meal. This was mentioned to the registered manager to address.

The staff training records showed they had received training considered mandatory by the provider. This included fire safety, first aid, health and safety, infection prevention and control, safeguarding, Team Teach (managing distressed behaviour), moving and handling, epilepsy, equality and diversity, medication, autism, MCA/DoLS and challenging behaviour. There were various other courses that specific staff had completed such as dementia care, end of life, nutrition and person-centred practice. Most staff had completed nationally recognised training in health and social care at various levels. The registered manager had completed a management course and the deputy manager, who was a qualified social worker, was working towards this. Staff told us they received sufficient training to enable them to feel confident when supporting people. A new member of staff described an induction process that included shadowing more experienced staff until they were confident to support people alone. They confirmed they were allowed time to read care plans and policies and procedures, and they had a mentor to provide guidance and advice.

Relatives of people who used the service told us staff were skilled in supporting their family members. Comments included, "I think she is very well looked after", "We are really pleased with the care; their health is closely monitored." A health professional said, "I know they attend various training courses within the council."

Records showed staff received supervision and annual appraisal. Staff confirmed this and described a supportive environment. We saw records which showed their practice was observed and feedback given to them to enable leaning to take place. Comments included, "It's a creative environment; you can put forward new ideas and they are willing to try new things", "We feel very supported" and "We have good management support."

The layout of the environment was suitable for people's needs. Corridors were wide and lounges were large enough to support people who may use wheelchairs to mobilise. There were grab rails, shower chairs and specialised baths to assist access. The current people who used the service were active and had few mobility issues. However, there were some bedrooms on the ground floor for people who had difficulty managing stairs.

Good

Is the service caring?

Our findings

Relatives were complimentary about the staff team and comments included, "Very nice staff; they keep you informed", "They are kind to her" and "They supported her to make a rose for me for Valentine's Day; it's the very best place she has been in. She loves the staff and sees it as her home, and always wants to go back." One relative described a kind act the staff team completed, which enabled the family to all meet up together.

A health professional described a situation when staff had supported one person in a compassionate way. They said, "With my client, when they moved into 220 Preston Road, they had not been on a holiday for quite a while and tended to focus on past experiences whether they were positive or not. Therefore, staff organised a picture board with different types of holidays, for example, beach, countryside or town. Once the type of holiday was picked, then the same process was used for accommodation."

We observed positive interactions with people who used the service and in discussions staff spoke about people in a warm, kind, caring and compassionate way. They said, "[Name of person who used the service] will choose the care worker they want to assist them; that's important to them." Staff described how they provided reassurance to some people when they needed it; we observed tactile response brought reassurance and comfort to people when needed. We observed staff supported people to access their favourite shops as part of their routine and we saw the pleasure this brought to people. One person carried their purchases back into the service and had a huge smile on their face; they had clearly enjoyed their trip out. Staff told us how it was important the person had this daily task as they looked forward to it.

The new deputy manager described how some people who used the service have developed close and trusting relationships with specific staff and had preferences regarding who supported them. They said this was respected as much as possible but all the staff team worked well with people. They told us, "I have been pleasantly surprised regarding the service user focus the staff have; they work hard to meet their needs and make sure they get out and about."

Staff were clear about how they maintained people's privacy and dignity and how they promoted independence as much as possible. Comments included, "We keep people covered during personal care and doors closed. We always knock on doors", "You have to be respectful, knock on doors and ask if we can come in" and "People choose their own clothing and we ask what they would like to wear."

Staff had developed a dignity tree in one of the corridors and staff were encouraged to make suggestions on stickers about how dignity and inclusion could be promoted. There were different themes at set times, for example how to improve dignity at mealtimes. Instead of each side of the building being called 'A side' and 'B side', staff were suggesting names to make the service more homely. The suggestions were to be discussed with people who used the service. A dignity champion had been appointed to ensure staff awareness and provide a lead role.

A health professional said, "I have seen staff offer the clients choices and respecting their dignity."

In discussions, staff were aware of the need to promote equality and diversity. Four staff had completed equality and diversity training and there was a policy and procedure to guide staff. There was also a code of practice for managers on religious and cultural needs in the workplace to guide them on the needs of staff when required. Other training had been identified and planned for April 2018 to explore staff's understanding of the sexual needs of people with learning disabilities and how to respond to them. The training was also to explore how to promote sexuality through care planning. In discussions with staff, they described how they saw people as individuals and tailored support to meet their individual needs. They spoke about people in a non-judgmental way even when they had managed some people's behaviour, which had been challenging to staff and other people.

People were provided with information on notice boards and during discussions with staff. There was written information about the day's menu on display in the dining room and we noted the need for pictorial menus to assist people in making decisions. The registered manager told us pictorial menus were on order and we saw these arrived in the service on the second day of inspection.

Staff were aware of the need for confidentiality and held meetings or telephone conversations with relatives or health and social care professionals in private. Personal records were stored securely and computers were password protected.

Requires Improvement

Is the service responsive?

Our findings

Records showed people had an assessment of their needs and input from health and social care professionals prior to admission to the service. Risk assessments were completed and the documents used to help develop plans of care, which guided staff in how to meet people's needs. Some risk assessments were generic and were completed for everyone whether or not the risk applied to them as individuals.

We saw there was an inconsistency with the quality of care plans and risk management plans. Some were very detailed, for example in how to guide staff in managing two people's behaviour, which could be challenging to others. There was also a very comprehensive plan to guide staff in how to recognise one person's communication methods. However, another care plan lacked important information. The person's specific behaviour was recorded, when and where it happened, but there was no plan for staff to respond to ensure this was managed in a consistent way. One person required a lap strap when they used a wheelchair in the community but this was not detailed in their care plan. Some people had profiles regarding how they took their medicines but for others, this was not clear.

The care plans had tick boxes which could be highlighted as 'always', 'usually', 'sometimes' or 'never' to describe specific tasks such as 'shaves independently' or 'can dry self with towel'. If 'sometimes' [they were independent] was ticked, there was no explanation of what happened on the times when they were not independent. The care plans recorded sentences such as, 'I rise early and need support from staff to shower and wet shave. I'm able to shave myself with an electric razor'. There was no staff prompt to ensure choice regarding shaving was asked and independence promoted first by offering the electric razor. There was no specific information regarding the level of support the person required when showering or what they could do for themselves to help maintain existing skills.

Information about people's needs was in lots of different places for example, personal profiles, assessments, risk assessments, some daily routine documents and care plans. We found staff had been good at identifying support needs but were not as clear when documenting how the needs were to be met in ways that met people's preferences. We saw issues had been highlighted in evaluations or reviews of the care plans and information was recorded in professional visitor's logs, for example, from dieticians. However, the information had not always been updated into the actual plan. Staff would have to read through all the evaluations to obtain the most up to date information. The registered manager told us they were in the process of reassessing the care plans as they had recognised the inconsistency.

We recommend the disjointed information in care files is reviewed and the system of planning care updated to ensure all the care plans record how staff are to deliver care and support in line with people's preferences.

We saw some personal preferences identified in profiles. This information told staff what was important to the person and especially what could cause anxiety. Despite the disjointed information in care files, we observed staff knew the people who used the service very well. They were able to describe people's needs and how they provided support meet them. The care described by staff and observed in practice was very

individualised.

Staff described the transition period for some people who had been admitted from another service; this had been completed carefully and had been responsive to their individual needs. It had been important for staff who knew the people well to transfer with them so continuity of care was maintained. Staff told us the transition process had gone smoothly and people had settled well into their new home.

Staff described how one person constantly asked which staff were on duty as the knowledge reassured and settled them. We discussed how this information could be provided to the person using a display system of the staff on duty in the person's bedroom and other rooms. Staff also spoke about writing the information down for them and this helped at times.

When asked if staff were responsive to people's needs, health professionals said, "Staff are very prompt and will call us with any concerns" and "Very prompt in informing me of changes in a client's health and seeks advice and follows it." Relatives also confirmed staff responded well to their family member's needs. They said, "They [staff] are there for her and they are able to do things with her" and "It's a relief knowing they are safe and looked after well."

Signage around the environment required improvement and some areas of the service lacked warmth and stimulation. For example, one lounge had very bare walls and no curtains; the registered told us pictures and curtains had been torn down. The second lounge had pictures painted on the walls and appropriate curtains in place. The registered manager explained the first lounge was to be decorated in time and they were sourcing curtains, which could be attached by the use of Velcro. We discussed the need for this to be completed quickly to make the room more homely and appealing.

The registered manager told us people were able to remain at the service for end of life care as it was their home; five staff had completed end of life training and there was a policy and procedure to guide them. The registered manager told us health care professionals would be involved when required. We saw the relatives of a person who had died last year had written a very complimentary card to the staff thanking them for their efforts in ensuring the person had a good quality of life. The card also commented on the kindness shown to relatives.

We saw people had daily plans regarding meaningful activities and accessed local community facilities. Staff assisted some people with daily living tasks such as tidying their bedroom, setting tables and vacuuming; some people cleared pots away after meals, washed them and wiped tables. There were activities within the service such as games, watching television, listening to music, using the sensory room and arts and crafts. We saw people also went swimming and bowling, to local shops, clubs, cafes and markets, and outings to the coast or museums. One person liked to visit charity shops to look at handbags and another liked to purchase ready-made coffee. Staff told us they made sure these activities were carried out daily for them. Staff recorded when people participated in daily activities and we observed them asking people what they would like to do and where they would like to go. When they were able to, people went on holidays each year. There were photographs around the service of people participating and enjoying activities. Specific staff were designated to ensure people were able to access the community.

The provider had a complaints policy and procedure. There were no formal complaints recorded and we discussed with the registered manager how the process could be made more accessible to people who used the service. We could not locate an easy read version of the complaints procedure and the complaints folder required updated information. Staff had access to policies and procedures on line and the registered manager told us the complaints folder was rarely used. They also confirmed they would locate an easy read

version of the complaints procedure and ensure this was made accessible to people. Relatives told us they felt confident in raising complaints. Comments included, "I don't have any complaints but if I did, I'd go to [registered manager's name] or adult social care" and "I'd speak to social services or [registered manager's name and deputy manager's name]. If they have concerns they ring me immediately."

Requires Improvement

Is the service well-led?

Our findings

There was a quality assurance system, which consisted of audits, checks, surveys and meetings. We saw action plans were produced when issues had been identified. There was a maintenance book to highlight any faults or repairs and these were reported so they could be addressed. There was also a health and safety checklist completed in January 2018 but some of the issues we identified had not been recorded. Issues that had been identified had not always been addressed in a timely way, for example, the cool temperatures of the hot water outlets in bedrooms and the leaking toilet on the first floor. Given the safety and cleanliness issues found during a tour of the environment, a thorough audit needs to takes place more frequently so issues can be addressed quickly. There needs to be a more robust system of overseeing the completion of domestic schedules. Following the inspection, we received copies of new documentation put in place to address the cleanliness issues. We also received a plan of refurbishment work, which had already been identified. There was no timescale for the plan to be completed. We saw new furniture for the lounges and dining room had been ordered.

The registered manager assured us work would be undertaken to address shortfalls in care planning and risk assessments.

Accidents and incidents were recorded and analysed so that learning could take place. Staff had been provided with arm guards to wear under clothing when supporting one person.

In 2017 surveys had been completed by relatives, staff and visiting professionals. Comments had been analysed and where required, short action plans had been produced. There had been a survey for people who used the service but this had been difficult as only one person was able to express their views; they did this by writing down their answer to the questions. The survey acknowledges this and reflects that staff answered questions for people by reading their body language and knowledge of their likes and dislikes.

There was a new registered manager and deputy manager in post and this new team was just getting established. The registered manager described a culture of the organisation as one of support and openness. They described involvement of senior managers and attendance at 'leadership meetings'. They confirmed senior managers visited the service and were able to pass on learning points from other local authority councils. The registered manager also attended 'manager's meetings' where they discussed issues such as best practice guidance and shared what went well in other services. They also attended 'registered providers meetings' to share experiences and exchange information. They described their own management style as firm but fair, respecting the uniqueness of individuals, whether this is people who used the service or staff, and ensuring they had an open door to discuss issues.

Staff spoken with were very positive about the changes in management and said it was an opportunity to have fresh ideas. Comments included, "The new management is really good and working well; they are bringing new ideas and it's positive", "It is a work in progress but it's a dynamic team", "It's a good atmosphere and we have teamwork; they listen to staff" and "We feel valued and [registered manager's name and deputy manager's name] are really putting their stamp on the place." Staff told us the registered

manager would assist with care tasks if required. All the staff spoken with were emphatic they would be happy for a relative of theirs to live in the service and be cared for by the staff team.

Relatives knew the names of both the registered manager and deputy manager. This showed us they had been in contact with them or made themselves known to them during visits. A health professional stated, "There is new leadership; this appears to have had a very positive effect."

Communication within the service was good. Staff had handovers of shifts and records were produced. These detailed who was on duty and any staff sickness, what people who used the service had done that day, whether there were any issues with medication to follow up and any maintenance repairs required. There was also a communication book that staff used to record important information such as medical appointments or reviews of people who used the service. There were staff meetings and records of them showed staff were able to raise concerns and make suggestions. There was a good record of the discussion, any actions that were required and whose responsibility it was to address them.

The registered manager was aware of their registration responsibilities in notifying agencies of incidents which affected the safety and welfare of people who used the service. The Care Quality Commission had received notifications of incidents in a timely way.

The registered manager had also built up good working relationships with colleagues in other departments of the local authority such as the safeguarding team and contracts and commissioning team. They contacted health and social care colleagues when required. They described a time when health professionals including a dentist, an anaesthetist, a GP, staff from the community learning disability team and staff from the service had met to discuss and plan dental care for one person who used the service. The meeting had gone well and the person received treatment. A health professional said, "I have found them open and honest. If they are experiencing difficulties, we work together to resolve these issues."

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured some risks and cleanliness issues had been identified and taken steps in a timely way to mitigate those risks. Regulation 12 (2) (d) (h)