The Otterhayes Trust

Otterhayes

Inspection report

Salston Ride
Salston
Ottery St Mary
Devon
EX11 1RH

Tel: 01404816300
Website: www.otterhayes.co.uk

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
The Otterhayes Trust provides accommodation and personal care for a maximum of six people living with learning disabilities and/or autism in a property known as Hayes House. At the time of the inspection there were five people living in Hayes House. This service also provides a domiciliary care agency service and provides support to a further 15 people living in seven supported living properties, with the aim that they can live as independently as possible. Two people living in the supported living properties were receiving personal care.

Our inspection carried out in September and October 2019 found that the service did not always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

This targeted inspection found the principles and values of Registering the Right Support and other best practice guidance had started to be implemented to ensure people lived as full a life as possible.

People's experience of using this service and what we found
During the inspection we spoke with two senior care staff. Following the inspection we spoke by telephone to six more. Overall staff said since the last inspection there had been some clear improvements. These included updated training on all key areas such as person centred planning, epilepsy, autism, infection control and safeguarding. Everyone we spoke with said this had been good and most could give an example of how this had impacted on their practice. For example, ensuring people could choose their own menus, choice of drinks, where they would like to go.

Staff said there had been improvements in the way they documented how they were working with people. Several staff said they had always worked in an inclusive and person centred way but they had not been good at documenting this.

At our last inspection there was a lack of adequate staff to meet peoples' needs placed people at risk. This targeted inspection found improvements had been made with staffing reflective of individual needs.

Staff said the management approach was moving towards being a listening and supportive approach. One staff member said, "The managers are respectful of staff, it seems to me they have worked very hard and when issues have been raised they have tried to address them."

Our observations of people showed staff interacting in a kind and respectful way. People appeared comfortable in their surroundings and several of them happily showed us their rooms and their homes which they were very proud of. During this inspection we spent a short time speaking with people who use the service and observing how staff interacted with them. It was clear people were comfortable in their

surroundings. Staff appeared to have good relationships with people and interactions were kind and responsive.

Plans were starting to be more person centred but this was still work in progress. Some of the information within plans was repetitive and long winded. Information at the start of one plan began with their negative behaviours. This is not in keeping with best practice for person centred care plans.

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

At our last inspection there were widespread and systemic failings identified; there were ten breaches of regulations. The shortfalls related to all the key aspects of the management of the service and included: safeguarding; safe care and treatment; person centred care; privacy and dignity; staffing; staff recruitment; complaints; statutory notifications, and good governance. This targeted inspection found improvements had started to be made. The service had brought in an interim operations director and an independent consultant to oversee operational and strategic practices. This has led to the service making improvements as cited in this report. Relatives confirmed that improvements were evident but recognised further improvements were needed.

The principles of good quality assurance as a tool to drive improvement had been gradually implemented in stages. The provider's service improvement plan was gradually attending to the deficits found at our last inspection and those identified through the whole home safeguarding process. Various audits had been implemented to oversee the running of the service. For example, audits covered ensuring care plans and risk assessments were up to date and accurate, infection control practices, incidents and accidents, staff personnel and training and activities.

At our last inspection records did not always contain the information required to protect people from the risk of unsafe care. There was also a failure to identify recording errors and omissions in people's care records to analyse to look for trends or patterns, such as behavioural charts or incidents. This targeted inspection found improvements had been made to how information is recorded. The registered managers had learnt that they needed to record everything and ensure they were robust in order to provide safe care and support. Further work was needed to how information is recorded as highlighted at the most recent whole home safeguarding meeting held on 23 July 2020. The provider acknowledged this and recognised systems were not entirely embedded in the service at the moment.

At our last inspection staff and relatives consistently told us that if they had any concerns or needed to raise a complaint either with the registered managers or the provider, they would not feel comfortable to do so due to the number of management and support roles held by family members. The targeted inspection found improvements had been made. The service has introduced an outside independent person for staff and family members to be able to talk to along with having external management present Monday to Friday as a point of call.

At our last inspection we had not received statutory notifications in relation to safeguarding events and serious injuries since October 2018. This targeted inspection found improvements had been made and we are now receiving notification appropriately in a timely manner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was inadequate (published date February 2020).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

The service continues to provide us with a monthly report in line with conditions that were imposed following the previous inspection.

At this inspection enough improvement had not been sustained and the provider was still in breach of regulations.

Why we inspected
We undertook this targeted inspection to check whether the service had addressed some of the concerns raised at our last inspection. .

CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. Therefore, the overall rating for this service has to remain inadequate as not enough areas were inspected in order to change the rating. We plan to return in the near future to carry out a further inspection which can potentially change the rating of the service.

Enforcement.
At the previous inspection there were ten breaches of regulation. These were in relation to breaches of regulation 9 (Person-centred care), regulation 10 (Dignity and Respect), regulation 11 (Need for consent), regulation 12 (Safe care and treatment), regulation 13 (Safeguarding service users from abuse and improper treatment), regulation 16 (Receiving and acting on complaints), regulation 17 (Good governance), regulation 18 (Staffing), regulation 18 (Notifications of other incidents) and regulation 19 (Fit and proper persons employed. At this targeted inspection we judged regulations 9, 12, 13, 18, 18 (registration), 11 and 16 no longer to be in breach. We identified continued breaches in relation to regulations 10, 17 and 19. We did not look at regulation 10 and 19.

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. Therefore, we decided that we will continue to regularly monitor the service, and have requested an action plan be submitted, to keep people safe.

Follow up
We will request a further action plan from the provider to understand what they will do to improve the standards of quality and safety. We will continue to work alongside the provider and the local authority to monitor progress. We have also been having regular meetings with the provider and there is an external consultant overseeing the service. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate.

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question inadequate.

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question inadequate.

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate.

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Otterhayes

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the service had addressed the concerns raised at our last inspection.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
The Otterhayes Trust provides accommodation and personal care for a maximum of six people living with learning disabilities and/or autism in a property known as Hayes House. At the time of the inspection there were five people living in Hayes House. 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.

This service also provides care and support to people living in seven supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support

The service had two managers registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We announced the inspection the day before we visited to discuss the safety of people, staff and inspectors with reference to Covid 19.

What we did before the inspection
Prior to the inspection we reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We also reviewed the information the provider sends us every month about the progress they are

making in meeting the breaches of regulation identified at our last inspection.

We spoke with various health and social care professionals as part of the whole home safeguarding process. We also requested three people's care plans, risk assessments and daily notes to be sent to us to limit the time required to be at the service.

During the inspection
We spoke with two senior care staff, the registered managers and interim operations director. We spoke generally with people living at Otterhayes and observed interactions between them and staff.

We also requested documents to be sent to us, including the training matrix, supervision records and various documents with regard to the running of the service.

After the inspection
Following the inspection we spoke by telephone to six more staff and the independent consultant. We sought feedback from health and social care professionals and relatives to obtain their views of the service provided to people. We received feedback from two professionals and four relatives.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the service had addressed the breaches of regulation at our last inspection.

We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection people were not consistently being kept safe and protected from harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

•At our last inspection people were not safe living at Hayes House. This was because staff were not up to date with their safeguarding training, did not follow local procedures when required and were not familiar with good safeguarding practice. Staff have now received up to date safeguarding training in order for them to understand what good practice is, how to report concerns and keep people safe.
•The service continues to be in the local authority whole home safeguarding process. This means the service continues to be monitored closely, with various professionals involved to ensure people are receiving safe care and support.
•During this inspection we spent a short time speaking with people who used the service and observed how staff interacted with them. It was clear people were comfortable in their surroundings and with the staff group who supported them.
•Positive feedback was received from relatives. Relatives commented: "With regards to (person's) care and support, the Otterhayes family (management, staff and residents) has always provided them with a caring and supporting home that is so important to their well being. I have never doubted Otterhayes' commitment to (person's) care nor the support from the staff", "(Person) is well cared for" and "(Person) is happy at Otterhayes."

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

•At our last inspection risks were poorly managed, and people were not involved in managing their risks. Practice at the service meant people were at risk of unnecessary harm to themselves, staff and others. There was a lack of individualised risk assessments in place. Staff were unaware of specific guidelines to manage risk because they were kept secured in the office where staff did not have access.
•This targeted inspection found improvements had been made. People now had individualised risk assessments in place for specific risks. For example, regards to possible choking if eating food too fast, management of epilepsy and behaviour management. Staff now had immediate access to risk assessments and guidelines since the introduction of an electronic system. This meant staff now had information accessible to meet people's needs and keep them safe.

Staffing and recruitment

At our last inspection the provider had failed to ensure adequate staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

•At our last inspection there was a lack of adequate numbers of staff to meet peoples' needs. This placed people at risk. The rota showed staffing allocation was based on locations and tasks rather than the needs of people.
•This targeted inspection found improvements had been made with staffing reflective of people's individual needs. A dependency tool has been introduced to determine staffing levels to ensure people's independent needs are met. The service has also increased night sleep in staff from one to two to ensure people's needs can be met in a timely manner. Rotas confirmed the increase in night support. The registered managers are also considering introducing a wake-in night shift.
•Due to the current Covid 19 pandemic we did not review staff recruitment records.

Preventing and controlling infection

At our last inspection lack of infection control training and management oversight did not ensure best practice was being followed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

•At our last inspection not all staff had completed infection control training, including the registered managers. The most recent infection control training was in 2016. We could not be sure that staff were following best practice guidelines.
•Staff now had up to date infection control training to ensure best practice.
•Staff had access to Personal Protective Equipment (PPE) to help manage Covid 19. In line with national guidance, both people and staff carried out effective hand hygiene and body temperatures checked on a daily basis. We observed the appropriate use of PPE during our inspection.
•The service had introduced an infection control champion to ensure best practice was followed in line with

government guidelines.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the service had addressed the breaches of regulation at our last inspection.

We will assess all of the key question at the next comprehensive inspection of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At our last inspection staff did not always deliver safe, effective and consistent health care. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

•At our last inspection the delivery of care and support was not consistently in line with best practice guidance. For example, the provider was not following best practice guidelines in line with Registering the Right Support (RRS) and British Institute of Learning Disabilities (BILD). The management team were unaware of this information and had not seen the guidance. This meant the providers were not adhering to the principles and values of the guidance such as people's choices, independence and decisions.
•This targeted inspection found improvements had been made. Care and support was being planned and delivered in line with best practice guidance. For example, care planning was in a more person-centred way with people's choices, control and independence at the centre of their support.
•At our last inspection prior to people coming to live at Hayes House, most people had received an assessment to ensure the service could meet their needs at the time. However, many of these assessments had not been reviewed and people's care plans not updated since 2013-16. Therefore, it was unclear whether the service could meet peoples' changed needs fully.
•This targeted inspection found improvements had been made with care plans and risk assessments being updated and reviews carried out by external health and social care professionals.
•People have had annual health check ups and medicine reviews were in the process of being arranged. A professional commented: 'The clients at Otterhayes are brought to the surgery when invited for their annual health care check up. This is part of the learning disability enhanced service and is very comprehensive in covering ongoing health needs, and health promotion.'

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff had the relevant training and support to do their job properly. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

•At our last inspection staff did not always have the skills, knowledge and competency required to do their jobs properly. This was because there was a lack of training undertaken. There was no overall training plan in place and the registered managers were not able to tell us how frequently they expected staff to complete training or what was considered mandatory. The registered managers asked us how they could access training in learning disability services. Not all staff had completed recent specialised training, such as autism and epilepsy.
•This targeted inspection found improvements had been made with a comprehensive training plan in place and staff completing training specific to people's individual needs. For example, staff had now received training on subjects including autism, epilepsy and learning disability awareness.
•At our last inspection there were deficits in staff training which included areas such as health and safety, first aid, basic food hygiene and fire training. This targeted inspection found improvements had been made. Staff now had up to date training on subjects including, health and safety, first aid, food hygiene and fire training. A relative commented: "The staff are very good, very caring."
•At our last inspection staff did not receive regular supervision and annual performance-based appraisals. Their hands-on practical competencies were not checked.
•This targeted inspection found that staff were now receiving regular supervision in order for them to feel supported in their roles and to identify any future professional development opportunities. Staff commented: "One to one supervisions have improved" and "I feel better supported to do my job."
•Training was provided by an external trainer commented: "I have undertaken the following courses for Otterhayes: Safeguarding – raising concerns, introduction to the Mental Capacity Act, learning disability awareness, epilepsy awareness, autism awareness, person centred practice and person centred planning. The team has been receptive to the learning and have participated well. It was clear at the beginning that staff were kind and well-intended but some of the views were outdated. This was especially noted in the Learning Disability Awareness Courses. It would appear that training had not been undertaken for a long time and appropriate induction had not been conducted."

Supporting people to eat and drink enough to maintain a balanced diet
•At our last inspection although the service recognised the importance of people having a healthy and varied nutrition in relation to the maintenance of good health and wellbeing, people were not always able to choose what they wanted to eat and drink.
•This targeted inspection found improvements had been made with people able to exercise choice over what they wanted to eat and drink. For example, house meetings had been introduced with regards to people choosing what they wanted to eat for their main meal and lunches. People were now involved in shopping and cooking food, such as making pizzas. Themed meals had been introduced. A staff member commented: "We have themed shared meals with projects in art to support this, such as a German and French day."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

At our last inspection staff did not consistently work within the principles of the Mental Capacity Act (2005). This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

•At our last inspection only six staff had completed MCA training in October 2017. Six staff had not completed the training, with the registered managers last completing this training in 2012. Six staff had completed Equality and Diversity training in October 2017. A further nine staff files showed they had not completed this at all. From reviewing people's care records and records of incidents, staff were not routinely implementing training into their practice. Where applicable, people's care records did not consistently contain capacity assessments.
•This targeted inspection found improvement had been made. Staff now had up to date MCA and equality and diversity training and were ensuring they implemented them in their practice. For example, ensuring people are able to make decisions about how they spend their day in line with their specific needs and preferences.
•At our last inspection consent to care, treatment and best interest decisions (BID) had not been obtained in line with legislation and guidance. There were many examples of staff making decisions for people who were unable to make choices for themselves. The guidance within the Mental Capacity Act 2005 had not been followed and BID had not been made by involving the relevant parties, such as health professionals and families.
•This targeted inspection found improvement had been made with mental capacity assessments and best interest meetings taking place specific to people's needs. For example, those relating to people's finances and the placing of door sensors on bedroom doors at night to alert staff if a person left their bedroom at night.

Inspected but not rated

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the service had addressed the breaches of regulation at our last inspection.

We will assess all of the key question at the next comprehensive inspection of the service.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection there were failures to ensure people received person-centred care and support. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

•At our last inspection care plans were kept in a separate office building. Staff told us the care plans were not used as working documents. They were undated or dated 2013-16 and not up to date. The registered managers said staff could access peoples' full care plan on the new electronic care planning system. However, when we tried to view this with staff it was impossible to read as such small text and could not be zoomed in on.
•This targeted inspection found improvements had been made with care plans being updated and being more easily accessible on the computer. On staff member commented: "There has been lots of changes around care plans which are much more detailed and more easily accessible on hand held devices and on computers."
•During the inspection we spoke with two senior care staff. Following the inspection we spoke by telephone to six more. Overall staff said since the last inspection there had been some clear improvements. These included updated training on all key areas such as person centred planning, epilepsy, autism, infection control and safeguarding. All staff praised the external trainer for their work in person-centred planning training. Everyone we spoke with said this had been good and most could give an example of how this had impacted on their practice. For example, ensuring people could choose their own menus, choice of drinks, where they would like to go.
•Staff had received training on person-centred planning. Staff commented: "We have received training on person-centred planning, this has helped the team be more positive and given them a better insight into people's needs. Being more individualised- trying to make sure we are offering more choices"; "We are more

conscious of trying to be person-centred looking at what each individual wants" and "I feel this fundamental training on person-centred approach is slowly being introduced to staff practice." A relative commented: "(Person's) care is personalised to her needs."
•Plans were starting to be more person centred but this was still work in progress. Some of the information within plans was repetitive and long winded. Information at the start of one plan began with their negative behaviours. This is not in keeping with best practice for person centred care plans.
•At the last inspection there were no records within peoples' houses to show how they communicated despite many people having limited verbal skills.
•This targeted inspection found individual planners and communication boards had been implemented in people's bedrooms to aid routines and communication.
•Goal setting for people has started to be implemented to ensure they live the lives they want to. For example, attending a football match and knitting a blanket for a relative.
•At the last inspection peoples' support information was kept in a range of documents rather than in a person's care plan. For example, in a sleep-in book, a location communication book, a general communication book and in team meetings. This meant staff could not be consistent in delivering care and management could not ensure peoples' full needs were known.
•This targeted inspection found improvements had been made with all notes documented in one place for staff to refer to in order to provide consistent care and support. A staff member commented: "The detail for what happens each day for people has improved so as a part time staff member she can see what had happened for people more easily."
•At our last inspection peoples' preferences, hobbies and interests were not considered. The service was run as a whole entity with people fitting into what staffing levels could provide and house routines. For example, activities took place mainly on a morning or afternoon.
•This targeted inspection found improvements had been made. The registered managers recognised they needed to tap in to things in the community. Prior to Covid 19, people engaged in a variety of activities of their choosing and were spending time in the local community on an individual basis. For example, disco in Exeter for people with a learning disability, linking with the community at the '7 – 9' club, drumming, swimming, shopping and meals out. During 'lockdown' due to the Covid 19 pandemic, people have been engaged in activities at Otterhayes. For example, parachute activities, exercises, dance, bingo, pamper sessions and swing ball.
•A monthly activities audit has been implemented to ensure people are engaged in activities and that daily records and care plans documented people's likes and dislikes.
•People were encouraged to maintain relationships with their friends and family. During the 'lockdown' due to the Covid 19 pandemic, people were encouraged to speak with family using various technologies.
•Relatives commented: I am very pleased to see an increase in outdoor / physical activities, which is important for (person)" and "(Person) is engaged in more activities."

Improving care quality in response to complaints or concerns
At our last inspection people did not feel comfortable raising concerns or complaints. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this targeted inspection and the provider was no longer in breach of regulation 16.

•At our last inspection staff and relatives consistently told us that if they had any concerns or needed to raise a complaint either with the registered managers or the provider, they would not feel comfortable to do so due to the number of management and support roles held by family members. There were no arrangements for any independent advocates for people or staff to contact.

•The targeted inspection found improvements had been made. The provider had introduced an outside independent person for staff and family members to be able to talk to along with having external management present Monday to Friday as a point of call. Staff and relatives confirmed they felt able to raise concerns and were listened to.

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the service had addressed the breaches of regulation at our last inspection.

We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure good governance of the service to ensure people were not placed at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

•At our last inspection there were widespread and systemic failings identified; there were ten breaches of regulations. The shortfalls related to all the key aspects of the management of the service and included:
•Safeguarding
•Safe care and treatment
•Person centred care
•Privacy and dignity
•Staffing
•Staff recruitment
•Complaints
•Statutory notifications
•Good governance
•This targeted inspection found improvements had started to be made. The service had brought in an interim operations director and an independent consultant to oversee operational and strategic practices. This has led to the service making improvements as cited in this report. Relatives confirmed that improvements were evident but recognised further improvements were needed to the management of the service in order for them to feel confident that people's care and support needs were being appropriately met.
•The principles of good quality assurance as a tool to drive improvement had been gradually implemented in stages. The provider's service improvement plan was gradually attending to the deficits found at our last

inspection and those identified through the local authority whole home safeguarding process. Various audits had been implemented to oversee the running of the service. For example, audits covered ensuring care plans and risk assessments were up to date and accurate, infection control practices, incidents and accidents, staff personnel and training and activities.
•The service continues to provide us with a monthly report in line with the notice of decision to impose certain conditions with regards to the running of the service which shows progress is being made as highlighted in this report.
•At our last inspection records did not always contain the information required to protect people from the risk of unsafe care. There was also a failure to identify recording errors and omissions in people's care records to analyse to look for trends or patterns, such as behavioural charts or incidents.
•This targeted inspection found improvements had been made to how information is recorded. The registered managers had learnt that they needed to record everything and ensure they were robust in order to provide safe care and support. Further work was needed to how information is recorded as highlighted at the most recent whole home safeguarding meeting held on 23 July 2020. For example, there was still some information in care plans and risk assessments which were not up to date and accurate. The provider acknowledged this and recognised systems were not entirely embedded in the service at the moment.
•The culture of the service still needed to improve to ensure it was individually person-centred for people. Staff appeared to have good relationships with people and interactions were kind and responsive. One thing we noted which may constitute a lack of person-centred approach was when one person asked if they could have a drink, the staff member said "yes coffee time is at 11, so soon." We explored this with the staff member who said it was to prevent them getting fixated on having lots of drinks. However drinks were made for everyone in the house at 11.

We recommend looking at established routines and checking whether these are always necessary and/or follow best practice guidance.

•Staff said the management approach was moving towards being a listening and supportive approach. One staff member said "The managers are respectful of staff, it seems to me they have worked very hard and when issues have been raised they have tried to address them."

At our last inspection we had not received statutory notification since October 2018. We use this information to monitor the service and ensure they respond appropriately to keep people safe. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this targeted inspection and the provider was no longer in breach of regulation 18.

•At our last inspection we had not received statutory notifications in relation to safeguarding events and serious injuries since October 2018.
•This targeted inspection found improvements had been made and we are now receiving notification appropriately in a timely manner.

Working in partnership with others
•The service continues to work in partnership with various health and social care professionals through the local authority whole home safeguarding process to ensure people are receiving safe care and support.