Precious Homes Limited

Prince Regent House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Prince Regent House 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.

This inspection took place on 6, 10 and 16 April 2018 and was announced. At the last inspection in January 2016, the service was rated as overall Good but we found that most staff had not undertaken training about autism. During this inspection, we found improvements had been made.

The care 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.

Prince Regent House accommodates up to ten people with learning disabilities and autism in one adapted building across three floors. At the time of this inspection there were nine people using the service.

There was a registered manager at the service. 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.

Staff were knowledgeable about safeguarding and whistleblowing procedures. The provider had safe recruitment processes in place. There were enough staff on duty to meet people's needs. Risk assessments were carried out to mitigate the risks of harm people may face at home and in the community. There were systems in place to ensure people received their medicines as prescribed. People were protected from the spread of infection. The provider analysed accidents and incidents and used this information as a learning tool to improve the service.

People's care needs were assessed before they began to use the service to ensure the provider could meet their needs. Staff were supported with regular supervisions and annual appraisals to ensure they could deliver care effectively. People were supported to eat a nutritionally balanced diet and to maintain their health. The provider and staff understood their responsibilities under the Mental Capacity Act (2005) and the need to obtain consent before delivering care.

Staff described how they developed caring relationships with people and demonstrated they knew what people's individual care needs were. People and their relatives were included in decision-making, care planning and care reviews. Staff were knowledgeable about equality and diversity. People were supported to maintain their independence and their privacy and dignity was promoted.

Care records were personalised and contained people's preferences. The provider reviewed people's care records regularly to ensure care was delivered appropriately. Staff understood how to deliver a personalised care service. The service had a complaints procedure and kept a record of compliments.

People and staff spoke positively about the registered manager. The provider had systems in place to obtain feedback from people, relatives and professionals about the quality of the service in order to make improvements where needed. People had regular individual meetings with staff to ensure they were happy with the support they received. Staff had regular meetings to keep them updated on care practice. The provider carried out various quality assurance checks to identify areas for improvement. The provider had invested in new technology to enhance the delivery of care.

We have made two recommendations about effective medicine quality assurance and end of life care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good.

Is the service effective?

Good

The service was effective. People had a comprehensive assessment of their care needs before they began to use the service.

Staff were supported through regular supervisions, appraisals and training opportunities.

People were given choices of nutritious food to eat. Staff supported people to maintain their health.

The provider had systems in place to ensure effective communication between staff within the service.

Staff understood their responsibilities under the Mental Capacity Act (2005) and the need to obtain consent before delivering care.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Prince Regent House

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 6, 10 and 16 April 2018 and was announced. The provider was given 24 hours' notice because the care service was a care home for younger adults who are often out during the day and we needed to be sure that someone would be in. One inspector carried out this inspection who was joined by a second inspector on the second day.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the evidence we already held about the service including notifications the provider had sent us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority to obtain their view about the service.

During the inspection we spoke with five staff including the registered manager, a senior care worker and three care workers. We also spoke with three people using the service and observed care given to two people in communal areas. We reviewed three people's care records including risk assessments, care records, medicines and finances. We also reviewed four staff records including recruitment, training and supervision. We looked at how the service was managed including policies and procedures, quality assurance documentation and records of meetings. After the inspection we spoke with one relative.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. A relative told us, "I think [family member] is over safe. They are very safety conscious."

Staff were knowledgeable about what actions to take if they suspected a person was being harmed. Records showed staff were up to date with safeguarding training. One staff member told us, "If we see anything that is wrong we have to report to the relevant authorities, could be CQC [Care Quality Commission], the police or safeguarding team." Another staff member said, "Make sure the person is safe. I would record everything they tell me. I would report to the manager what is happening. I could whistleblow to my manager, CQC and the safeguarding team."

The provider had comprehensive safeguarding and whistleblowing policies which gave clear guidance to staff on what to do if they suspected someone was being abused. Records showed the local authority and CQC were notified when there was a safeguarding incident.

People had robust risk assessments carried out to mitigate the risks associated with receiving care at home and in the community. Risk assessments included emotional needs, vulnerability to abuse, community access, social isolation, public transport, the home's vehicle, shopping and use of the swing, trampoline and hot tub at home.

One person had a risk assessment for the communal kitchen and using appliances. The risk management guidelines included, "[Person] to have constant supervision in the kitchen so [they are] not at risk of burning [themselves]. [Person] likes shiny items and items such as stickers/magnets and will try to re-arrange items in the kitchen. Staff supporting [person] to engage and re-direct [person] to the activity that is being carried out."

People who had behaviours that may challenge the service had behaviour support plans. These documented what the behaviours and possible triggers were, how to prevent the behaviours occurring, how to react to the behaviour and support needed afterwards. Care plans contained detailed guidelines on the use of physical intervention and the type of hold that could be used safely with the person.

Staff received advanced training in crisis prevention and intervention techniques (CPI). People's care plans and risk assessments indicated that physical intervention was only to be used as a last resort. For example, one person's support plan stated, "CPI should only be used if there is a risk to [person's] or other's safety."

The provider had a policy about managing people's money. Each person's care plan detailed the support they needed to manage their money. The service had safeguards in place to ensure people's money was safe which included storing money in locked safes. Records were kept of money held, receipts were kept of money spent and staff were required to sign whenever they spent money on behalf of a person. We checked the amounts and records of money held on behalf of people and found these were correct. The above meant people were protected from the risks of abuse or harm.

The provider had taken reasonable steps to protect people from the risks of fire. Each person had a personal emergency evacuation plan and a fire risk assessment had been carried out on 30 June 2017. Fire-fighting equipment was last checked on 27 November 2017 and the weekly fire alarm test was up to date with no concerns identified.

Building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, a gas safety check was done on 6 November 2017, the five year electrical installation check was done on 23 December 2016 and portable electrical appliances were tested on 30 October 2017. We noted during the inspection that a shed containing tools was unlocked. However, when we raised this with the registered manager a suitable padlock for the shed was purchased immediately.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had given written references. New staff had criminal record checks to confirm they were suitable to work with people and the provider had a system to obtain regular updates. This meant a safe and robust recruitment procedure was in place.

There were enough staff on duty to meet people's needs. A relative told us, "There is enough staff. [Family member] has always got two [staff members] with him." Staff confirmed there were enough staff on duty. One staff member said, "I think there is an adequate number of staff."

Duty rotas showed people were supported by one or two members of staff during waking hours according to their assessed needs. There were 15 staff on duty during waking hours for the early and the late shifts and two staff who covered the middle part of the day to enable staff to take breaks. The rota showed there were nine staff on duty during the night. During the inspection we observed staffing levels were in line with people's assessed needs.

Staff confirmed they had received training before being able to administer medicines. One staff member told us, "Before you can even go into the medicines room you have to be trained." Records confirmed staff who administered medicines had received training which included an assessment of their competency.

The provider had a comprehensive medicine policy which gave clear guidance to staff of their responsibilities regarding safe medicines management, Medicine administration record (MAR) sheets were completed correctly. Two staff were required to sign to confirm medicines had been administered. There were no gaps in signatures indicating people had received their medicines as prescribed.

Some people had been assessed to self-administer their medicines and had lockable medicine cabinets in their flats. Medicines for other people who needed assistance were stored in a locked cabinet inside a locked room. Some prescription medicines are controlled under the Misuse of Drugs legislation to prevent them being misused, being obtained illegally or causing harm. The provider had effective systems in place to ensure controlled drugs were stored appropriately and correctly accounted for in line with current legislation.

People who required 'pro re nata' (PRN) medicines had clear guidelines in place. PRN medicines are those used as and when needed for specific situations. We found one issue with a PRN medicine for pain for one person where the amount of tablets in stock did not tally with the amount recorded on the MAR sheet. Immediate action was taken and the issue was raised with the staff member responsible for the recording error.

The provider had a comprehensive infection control policy which gave clear guidance to staff on preventing the spread of infection. There were adequate hand washing facilities throughout the building including soap dispensers. Staff confirmed they were provided with sufficient personal protective equipment (PPE) such as disposable gloves and aprons. One staff told us, "PPE is falling out of our ears and too many gloves." Another staff member told us, "Yes we get loads of that." This meant people were protected from the spread of infection.

The provider kept robust records of accidents and incidents. Records showed these were analysed for each person on a monthly basis so that lessons could be learnt. Each incident form had a space for learning outcomes to be documented. For example, an outcome on one behaviour incident form stated, "[Person] appears to be unsettled each time [person] saw a lot of staff around [person]. Shift leaders to make sure not more than two staff around [person] whilst in the project." This meant the provider had a system to ensure lessons were learnt from accidents and incidents and actions were taken to prevent reoccurrence.

Good

Is the service effective?

Our findings

People had a comprehensive assessment of their care needs before they began to use the service. The needs assessment included the person's history, what was important to the person, communication needs, health and medication needs. Each person had a one page profile which summarised who the person was and what support they needed. For example, one person's profile stated, "Staff to use a calm and gentle voice when talking to me. To use visual material e.g. pictures, photos when trying to make choices. Give me a maximum of three choices at a time, so I don't get confused when making a decision." This meant the provider ensured they could meet people's needs before accepting them into the service.

Staff confirmed they received regular opportunities for training. One staff member told us, "I've done lots of training since I've come." Another staff member told us, "We have training going on right now in care skills. We have refresher training." Records showed the training staff received included autism awareness, challenging behaviour, fire safety, food safety and first aid. The training matrix highlighted when staff were due for a refresher so that the training could be arranged.

New staff received comprehensive induction training before they began working with people. During the induction period staff read people's care files and were 'buddied' with experienced staff who they shadowed. New staff then attended the head office for two days to receive training in safeguarding, whistleblowing and the provider's expectations of staff. The registered manager told us new staff had to complete a six month probation period. Staff and records confirmed this was the case.

Records showed that new staff were required to complete online training within a twelve week period and complete an induction booklet. Training records showed staff completed the Care Certificate which is training in an identified set of standards of care that staff are recommended to receive before they begin working with people unsupervised.

Staff confirmed they were supported with regular supervisions and appraisals. One staff member said, "[Supervision] can be a sounding board or it can be to get something off your chest." Another staff member told us, "[Supervisions] are useful. It helps you keep track on your own self and look at ways we can improve ourselves. We talk about any ways [supervisor] can support and help me." A third staff member said. "Appraisal is like a bigger supervision. If you feel you are not doing well you can be told you are doing well which gives you confidence."

Records showed staff received supervision in line with the provider's policy. Topics discussed included the well-being of the staff member, whistleblowing, safeguarding and the needs of people using the service. Annual appraisals looked at the staff member's performance over the last year, what was working and what was not working well. The above meant staff were supported through training, supervisions and appraisals to carry out their role effectively.

People told us they liked the food they were given and named their favourite foods which included pasta, bacon, eggs, chicken, pepperoni pizza and cultural dishes. A relative told us their family member was given

choices of the food they ate. Menus showed that people were encouraged to eat a healthy diet as well as their favourite foods. We observed the kitchen was stocked with fresh and nutritious food.

Staff demonstrated they were knowledgeable about people's dietary requirements. One staff member told us, "Yes they all have their own individualised menus. They can change their mind from day to day. Everything is their choice." This staff member explained that one person used Makaton and picture cards to indicate their food choices. Another staff member said, "I would say they have food choices because we tend to speak to them. We prepare a weekly menu for them and we find out what they would like on the menu."

Menus showed that people from different ethnicities were catered for. We saw that one person had a themed birthday party around their cultural identity. A staff member explained how they had introduced jerk chicken for people who were of Caribbean origin and how they tried to include African flavour into the food for people of this ethnicity. People's menus were displayed in the kitchen and were pictorial. This meant people were provided with nutritionally balanced food of their choice.

Staff confirmed there was good communication within the service. One staff member told us, "I think it's pretty good. We have handovers. [Staff from previous shift] will usually tell me before they go home what is happening." Another staff member said, "That's the reason we have handovers. We have a medicine communication book to pass information about changes in medicines to other staff." Records confirmed there was a staff handover when there was a change of staff on shift and any changes in people's needs were discussed.

Staff described how they supported people to maintain their health. One staff member told us, "If somebody appears unwell we would ask them how they feel. We make their appointments in the morning and when we come back we write a professionals report and we report to the family." Another member of staff said, "I do go with people to medical appointments. All the staff are able to make appointments."

People had access to healthcare as needed. Care plans included reports from health professionals, medical correspondence and hospital passports. Healthcare appointments were documented and included the dentist, optician, GP, physiotherapy and psychiatry. This showed the provider worked jointly with outside agencies to ensure people received the healthcare they needed.

The building was laid out across three floors accessible by stairs. Each person had their own bedsit or bespoke flat within the building where they could spend time away from other people or they could choose to socialise in the communal areas of the home. People could make use of the outside garden area which contained a swing, trampoline, hot tub and a built-in barbecue. Although there was no lift in the building, people with mobility difficulties could occupy the rooms on the ground floor.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of this inspection, each person using the service had an authorised DoLS in place because they required a level of supervision at home and in the community that may amount to their liberty being deprived.

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. Staff demonstrated they understood the principles of the MCA. One staff member told us, "We've got to assume [people using the service] have got mental capacity unless it's proven otherwise. DoLS can be locks on doors or using restraint. It needs to be written into their care plan."

Staff described when they obtained consent from people who used the service. One staff member told us, "I get consent to go in their room. I always ask if they mind if I sit next to them." Another staff member said, "We would ask them if they are ready to take their [medicines], even to go into a [person's] room and if they needed help with any parts of their personal care." A third staff member said, "It depends on what the situation is. It's about speaking to them about it. If it's okay with them we go ahead but if they say no, we try to reassure them and explain the benefit but if they still say no we have to respect their wishes." The above meant the provider worked within the requirements of legislation.

Good

Is the service caring?

Our findings

People told us they thought staff were caring. One person said, "Staff are nice and caring." Another person named their favourite care worker and said this was because they wore, "sophisticated, cultural clothes." A relative told us, "I've met a lot of [staff] and [family member] is fine with them."

Staff described how they formed caring relationships with the people they supported. One staff member told us, "I find out what [person] likes, what things they are interested in by generally speaking to them. I looked at their care plan." Another staff member told us, "Read through their care plan first. By interacting with them and getting to know them. By working with them you get to understand them better." A third staff member said, "When I first started, they gave me a file for each service user so I went through that. The only way you can get to know them is to spend time with them."

The provider had a "keyworking system" where each person who used the service had named care workers. A "keyworker" is a staff member who is responsible for overseeing the care a person received and liaising with other professionals or representatives involved in a person's life.

The service included people's families in care planning. A relative told us, "They [staff] send me reports every week." The registered manager told us, "We have [care] reviews. We ring the families and they get their weekly updates. We have events for families and professionals. We tried coffee mornings but the [people using the service] find this too intrusive." One staff member said, "Parents do come around and we always involve them in the decisions and they take part and will give us the go ahead. At the end of the day it is about the [person using the service] interests and it's about openness."

People were involved in making choices. One staff member told us, "They can change their mind. If they want to do something different they can." Another staff member said, "We are not institutionalised. It's about choices. We can show them how to do [a task], teach them, prompt them and they might decline. We have to respect that." A third staff member told us, "We always give them choice of everything."

Care plans gave guidance to staff on how to support people to make choices and decisions. One person's care plan stated, "Support me to understand what the decision is about and give me all the information I need in order to make the decision. Do not give me too many choices. Show me what the choices are visually." These guidelines included how the person liked to be given information and the best times to ask them to make decisions. The above meant people were involved and supported in decisions about their care.

The provider had an equality and diversity policy which gave clear guidance to staff about what was expected of them. Staff demonstrated they knew about equality and diversity. One staff member told us, "Basically there is no [person] who has favouritism over another. We have to treat them equally. A [person] who does not feel appreciated will not be happy. As a support worker we promote fairness." Another staff member said, "We treat them equally, talk to them with respect and treat them the way you would like to be treated."

The registered manager and staff were knowledgeable about each person's cultural needs. The registered manager said about one person, "We have tried to support them to [place of worship]. However crowds are difficult [for person] so it did not work and at this time, [person] has shown no interest in their religion." A staff member told us, "The food, I think it's really important to maintain that." This staff member told us one person went to their chosen place of worship regularly. Care plans included people's religious and cultural needs. For example, one person's care plan stated, "Although I do not practice my religion I must be given an option to if I wish to do so in the future."

The provider had a relationships and sexuality policy which gave guidance to staff on how to support people with their relationship needs. We asked the registered manager if people's 'significant other' would be able to stay overnight. The registered manager told us, "Depending on capacity and a best interests meeting, I would look at the risks for the home. Involvement of all the professionals who need to be involved. Then yes, it could be possible." The registered manager also said that each person's flat could accommodate a family member and, "We plan to obtain a [sofa bed] for a family member to use"

The registered manager explained how the service would support a person who identified as lesbian gay bisexual or transgender (LGBT). They told us, "It would depend on the assessment and the level of their need. I would make sure whatever they needed is provided. Arrange for them to attend events if they wish. We incorporated a discussion into staff meeting and staff opened up to discuss equality issues." One staff member said, "This is part of the training we get here. I think everyone's entitled to whatever sexual orientation they are. I would not treat them any different to any other person. They deserve to be treated equally. That is the focus of what we are doing here. Whether it is culture, religion or sexual orientation." This showed people were supported with their equality and diversity.

The provider had a dignity and care policy which gave clear guidance to staff on what was expected of them. Staff were observed to knock on people's doors before entering their flats. One staff member said, "Their dignity is being promoted by if you look around the home they have their own flat and before we go in we have to knock. We give them the guidelines to always have something wrapped around them before they open the door. It's about understanding [people who used the service]." Another staff member told us, "When we do medication, that's a time we have to look after their privacy and dignity. It's always best to do it in their rooms. If a [person] needs personal care, they might request a male or female [staff]. We keep doors closed while they are having personal care." A third staff member told us, "We need to shut the door and curtains, tell them what you are there to do, ask them if it's okay if you do it." This meant people's privacy and dignity was promoted.

People using the service were supported to maintain their independence. One staff member said, "We try to promote independence with cooking and the washing-up. I'm all about people being independent." Another staff member told us, "By getting them to do for themselves what they can do. Waiting and giving them time to process and then they do the task." A third staff member said, "As time goes on let them do more say for cooking." This showed people were supported to maintain their independence.

Good

Is the service responsive?

Our findings

A relative told us staff were responsive to their family member's needs. They said, "[Family member] tells staff what he wants to do. They listen to what he says."

Staff demonstrated they understood how to provide personalised care. One staff member told us, "By providing the topmost care for that person where that person is the centre of everything. Everything that is being done is being done around that person. How you work with that person is making them at the centre of everything." Another staff member told us, "It is about focussing on the service user." A third staff member said, "We let them do their thing. If that's what they want to do we let them do it."

Care records were very detailed, personalised, pictorial and contained people's preferences. Support plans included the person's history, dreams for the future and what a good and bad day looked like for them. Care plans contained information about what people liked and admired about them. For example, one person's care plan stated, "My collection of dolls, my appearance, my artwork, my smile, my caring nature, having good chats with me, my sense of humour."

Care plans gave clear guidance to staff on how to support the person in different situations. One person's care plan included, "Give me time and space to do the things I enjoy doing. Be aware of the environment and when out in the community as I do not like dogs so I will need staff to distract and divert me if I see them." Another person's care plan gave information about their mobility needs and included, "I can move around and walk by myself, but at times I may need support from staff by linking arms. Staff to support me when I walk, allow me to link your arm in order for me to remain steady on my feet."

Care plans were regularly reviewed. Each person met with their keyworker weekly to determine what was working well and what was not working well. This information was referred to at the monthly care plan reviews. Staff signed to confirm they read and understood each section of the care plan. The above showed the provider was knowledgeable about providing care in line with people's preferences and changes in needs.

Providers must evidence they record, flag and meet the accessible communication needs of service users. We observed there was a staff board with pictures of all the staff. There was also another board containing fun facts about each person who used the service. Each person had communication guidelines contained in their care plans. These showed that Makaton and social stories were used to help people to communicate.

People's support plans were easy read and pictorial. One person's support plan stated, "Uses a now and next board because [person] is very much in the 'here and now' and longer schedules are not helpful." The board showed the person what they were going to do now and what would happen next.

Care records showed a staff matching support sheet which detailed the skills needed from a carer, personality and characteristics needed, support needed and wanted and shared common interests. For example, for one person the skills that were needed included, "A solid approach, responsive, supportive,

patience and effective communication including the use of Makaton and pictures." A staff member told us the registered manager had asked about their interests at the interview process for matching processes. This staff member was interested in technology and was matched with a person using the service who also had this interest.

Each person had their individual timetable of activities which included walks, cycling, bowling, trampolining, artwork, swimming, attending a place of worship, day centre, going for a drive, train or bus ride. Two people participated in looking after the vegetable plant boxes in the garden area. We noted one person has sensory ball spinners on the wall outside their flat which they enjoyed using. The registered manager told us the walls had recently been painted and they were planning to put up photograph displays of activities.

People told us they enjoyed the activities they participated in and comments included, "Playing cards. I like it here 'cos you can go out anywhere. Went out today and bought scrabble [board game]", "Stories, painting, writing, eating food. I went to [supermarket] today. I bought shopping" and "I like the cinema."

The registered manager told us, "We had a Caribbean theme day the week before Easter and had a Christmas party with families. We are having an African themed night next month and planning a British night with pie and mash or fish and chips. Last year we did coloured t-shirt day for Autism Awareness Day."

People and their families knew how to make a complaint and said if they were not happy with anything they would raise it with their chosen staff member or the registered manager. There had been no complaints made since the last inspection.

The provider had a complaints procedure which gave clear guidance to staff about how to handle complaints. Staff were knowledgeable about how to handle complaints. One staff member told us, "Record what they have to tell me and I would always take it to my manager or a senior." Another staff member said, "I would listen and I would record it and report to my line manager to inform of what the complaint is about so we can find a way to resolve it." A third staff member told us, "If they wanted to make a complaint, then they could talk to me and I could pass it on to the manager." This meant the provider had a system to use complaints to improve the service provided.

The provider kept a record of compliments and we saw four compliments were made since the last inspection. One example was a family had written, "We have seen a marked difference in [person's] behaviour. He was calmer and relaxed and he seemed to enjoy the visit a lot more than before. We feel that the staff always deal with any issues that arise very quickly and they always deal with [person] in a fair and reasonable way."

The service consisted of younger adults and at the time of this inspection there was nobody receiving end of life care. The registered manager told us they planned to discuss end of life care wishes with people and their families at their annual reviews and person centred planning meetings. The provider had an end of life policy. However although the policy gave clear guidance to staff about supporting people to have their wishes fulfilled after their death, there was no guidance for staff as to how to support a person during the time leading up to their death. This omission could mean people's wishes for their last days of life would be unfulfilled. We recommend the provider seeks advice and guidance on effective end of life care planning.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. The registered manager told us, "I'm a very open manager. I don't sit behind a desk. Where I can support staff with certain problems I will. My phone is available 24/7."

People and relatives told us they thought the management of the service was good. One person told us the registered manager was their favourite out of all the staff. Another person, "Registered manager is alright. We have a chat about things that are important."

Staff told us they felt supported to do their job. One staff member told us, "[Registered manager's] door is always open. If I had anything I needed from her as the manager I know she would do it." Another staff member said, "I think [registered manager] is a very good manager. It is mainly her who has given me support in the past. She leads from the front. I've never seen her tell people to do things that she would not do herself." A third staff member told us, "She's the best. With her you feel you can say anything to her. She is always there with a listening ear. She will always want to bring out your potential. She's one of the best managers I have had."

The provider had systems of obtaining feedback to make improvements to the service. We saw positive comments were made during a survey supplied to relatives and professionals in 2017. One relative had said, "So far all staff have been very fair and kind. From what we have seen [family member] has as much freedom as he can have." A professional had written, "Prince Regent have provided care and support in an appropriate manner effectively and to a very high standard. I feel that the management team work effectively in ensuring that all staff are aware and supported to work effectively with clients."

The survey for people using the service was pictorial and had tick boxes to make it easier for people to understand and complete. We reviewed surveys carried out with people using the service in 2017 and noted these were positive. One survey documented the person said they liked talking to the staff. Another survey for a person documented, "My support staff listen to me. I have a good relationship with staff. My staff support me to do the activities that I enjoy."

The provider had a system of holding individual meetings between people and their keyworkers rather than group meetings. We reviewed the minutes of individual meetings held during March 2018. Topics discussed included budgeting, college, health, food preferences, diversity, activities, security and life in Prince Regent House.

Staff confirmed they had regular meetings and told us they found these meetings useful. One staff member said, "Yes very much [useful]. There's sufficient time and we can ask whatever we want." Another staff member told us, "It's an avenue in which we can raise issues and as a team we can resolve issues."

Records showed that staff meetings occurred monthly and were held separately for day staff and night staff. We reviewed the minutes for staff meetings held in January and February 2018 and saw topics discussed included handovers, shift leader duties, log sheet completion, medicines, the needs of people who used the

service, whistleblowing and communication.

The registered manager told us, "Staff meetings have an agenda but I am more interested in the AOB's [any other business agenda items]. I might chuck something in there that gets the ball rolling, like, 'I can't wait to go on holiday' or 'I'm so tired'." This meant the provider had a system to keep staff updated on care practices.

Staff told us the provider promoted staff equality and diversity. One staff member told us, "We are like a family. We relate and share cultural values. The company actually supports diversity and equality." Another staff member said, "Staff are supported to have time off for religious reasons."

The provider had various quality audit systems in place. We reviewed an audit carried out by the provider's head of quality and risk management and an external quality consultant on 21 February 2018. This audit used the same key lines of enquiry that CQC use in inspections.

The documentation showed where issues had been identified, an action plan was drawn up and individual actions were ticked off when completed. For example, the audit identified that maintenance work was needed in one person's flat and there was no record of this being raised when it was first noticed two days previously in order for a repair to be arranged. The auditors arranged an emergency call to be made to the local maintenance person. Records showed that arrangements were made for the work to be carried out whilst the person was staying with family.

The provider had a service improvement plan dated 28 February 2018. This showed actions identified, the outcome and the timeframe with which it must be completed. For example, one person was noted as needing a PRN protocol to be completed and signed by the psychiatrist. The audit noted that the protocol was completed.

Records showed the registered manager carried out a management audit of the service which included an overall check of care files, medicines, environment and finances. The registered manager told us an additional audit system was being introduced May 2018. This would involve the registered managers of two services carrying out checks of each other's services.

The registered manager, deputy managers and senior staff carried out regular checks of finances, medicines, care files, actions outstanding from the improvement plan and medicines. The weekly physical environment check listed maintenance jobs to be done. Records showed this audit was up to date.

The medicines audit carried out on 8 April 2018 noted that one person needed allergy information updated. This action was signed to indicate it was completed and records confirmed this was the case. However we noted there was no place in the audit for medicines that enabled the management team member to check the amounts of medicine in stock against the records. We recommend the provider seeks advice and guidance about effective quality assurance systems for medicines.

The service had recently started using technology, 'Nourish IT system' to enhance the delivery of effective care and to promote people's independence. Activity notes were being recorded on this system and the service was in the process of adding care records to the system. Staff used two way radios to enhance staff communication and enable more effective support to be given.

The registered manger told us about the work they had done to form good relationships with the neighbours. This included inviting neighbours to event days held within the home to help their

understanding of the people using the service. The registered manager showed us where they had made a fence higher because a neighbour had said the low fence was intrusive on their conservatory. This showed the provider worked to form links with the local community.