

Hollybank Trust

Rowan Court

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 21 June 2016 and was unannounced. This meant the registered provider did not know we would be visiting. The service was last inspected in July 2014 and was meeting the regulations we inspected at that time.

Rowan Court is part of Holly Bank Trust, which is an organisation specialising in providing education, care and support for young people and adults with profound and complex needs. It is based in purpose built premises on the grounds of Holme Valley Memorial Hospital, close to Huddersfield. It provides care and accommodation for up to 15 people. At the time of our inspection 15 people were using the service.

There was a manager in place but they were not a registered manager. 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. The manager was leaving the service at the end of June 2016 and a new manager had been appointed.

Risks to people using the service were assessed and plans put in place to minimise the chances of them occurring. However, we saw that risk assessments were not always reviewed by their stated review date. Risks to people arising from the premises were regularly reviewed.

Emergency plans were in place to support people safely in emergency situations, though they were not easily accessible. There was a business continuity plan in place to help provide a continuity of care in situations where the service was disrupted.

Accidents and incidents were monitored by the manager and registered provider and steps taken to minimise the risk of them occurring.

There was a safeguarding policy in place and staff understood the types of abuse that can occur in care settings. The safeguarding policy contained guidance to staff on indicators of abuse and how they should report any concerns they had. Staff confirmed there was a whistleblowing policy in place and said they would use it if they had any concerns.

People's medicines were managed safely. People's medicine support needs were set out in a medicine care plan. Protocols were in place providing guidance to staff on people's 'as and when required' medicines. Controlled drugs were securely stored and regularly monitored.

Procedures were in place to ensure safe staffing levels. During the inspection we saw that people were attended to quickly and staff were attentive to people in their own rooms and communal areas. Staff told there were enough staff employed to support people safely. Procedures were in place to minimise the risk of unsuitable staff being employed.

Staff received mandatory training in a number of areas, but was not always refreshed in line with the registered provider's policy to ensure it reflected best practice.

Newly recruited staff completed an induction programme before they could support people without supervision. Staff we spoke with confirmed they had completed the induction programme before supporting people on their own.

Staff were supported through regular supervisions and appraisals. Staff also completed competency checks in areas such as moving and handling and medicines to see if further training was needed, and we saw records of these in staff files.

The service worked within the principles of the Mental Capacity Act 2005. Everyone using the service was subject to a DoLS authorisation. The manager kept a chart showing when these had been granted, when they expired and any conditions that applied. This helped ensure that any renewal applications were made in a timely manner. Where people lacked capacity to make some decisions they were still encouraged and supported to decide things they were capable of.

People were supported to maintain a healthy diet. Care plans also contained evidence of the involvement of other professionals such as dieticians and speech and language therapists (SALT) to help people maintain a healthy diet. People's weights were monitored and their food and fluid intake recorded to ensure they were receiving enough food and drink. Each floor had its own food budget, and people went on a weekly shopping trip to decide how this should be spent. People were also involved in planning a weekly menu, and we saw that people had their own choice of foods in addition to that bought for everyone.

The service supported people to access external professionals to manage and promote their health. Professionals such as occupational therapists, nurses, speech and language therapists (SALT), dieticians and physiotherapists were involved in developing people's care plans to ensure they effectively met people's health and support needs.

People were able to communicate to us that the support they received was caring and they were happy at the service. People communicated that they got on well with the staff who supported them.

Staff used Makaton and individually tailored hand, eye and facial expression communication techniques to interact with people. Staff were committed to using techniques that worked best for the person involved.

There was a presumption that people could understand what the conversation was about even though they did not always respond, which created an inclusive and homely atmosphere. People were treated with dignity and respect and staff were attentive to people's needs.

At the time of our inspection no one at the service was using an advocate. There was no advocacy policy in place but the manager was able to describe how they were working with the local authority to arrange an advocate for a person using the service.

No one was receiving end of life care at the time of our inspection. The manager told us how this would be arranged if needed.

Care was planned and delivered based on people's assessed needs and preferences. Care plans were produced on the basis of people's assessed support needs and reviewed every six months. Staff said they would be updated sooner if there were any changes to people's support needs. Daily notes were used to

record care and support delivered. This helped ensure that staff changing shift had the most up-to-date information on the person.

People were supported to access activities based on their preferences and abilities. People had an individual activities timetable, and these were also displayed in communal areas. Where appropriate, risk assessments were in place for physical activities to help people access them in a safe way.

There was a complaints policy in place. This provided guidance on how complaints would be investigated and the timeframes for doing so. There was also an easy read 'complaints folder' on display throughout the service. Records confirmed that investigations had taken place and outcomes had been sent to those involved.

The manager and registered provider carried out a number of quality assurance checks at the service, but these were not always effective at monitoring and improving standards. The audits had not identified the issues we found with overdue risk assessments and training. The manager did not carry out overall checks of the audits to see if they were effectively monitoring standards.

Staff spoke positively about the culture and values of the service. Staff said they felt supported by the manager, including in staff meetings where they could raise any concerns they had.

Feedback was sought from relatives of people using the service in annual questionnaires. People using the service were not asked to complete a questionnaire but throughout the inspection we saw staff asking how they were. There was an easy to read feedback folder on each of the three floors, containing charts with symbols depicting moods and feelings. This was used to help people give staff feedback.

The manager understood their role and responsibilities, and was able to describe the notifications they were required to make to the Commission.

We found two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014, in relation to the effectiveness of risk assessment reviews and quality assurance processes and staff training. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People's medicines were safely managed.

Recruitment systems were in place to minimise the risks of unsuitable staff being employed.

Staff had an understanding of safeguarding issues and the action they would take to ensure people were safe.

Risk to people using the service were assessed but not always effectively reviewed.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff received the training they needed to support people effectively but training was not refreshed in line with the registered provider's policy.

The service was worked within the principles of the Mental Capacity Act 2005 and supported people to make decisions themselves.

People were supported to maintain a healthy diet and were involved in planning meals.

People were supported to access external professionals to maintain and promote their health.

Requires Improvement ●

Is the service caring?

The service was caring.

People were treated with dignity and respect by staff who knew them.

Staff took the time to deliver support in a kind a caring way.

Staff were very effective in communicating with people and

Good ●

supporting them to express themselves.

Procedures were in place to arrange advocates and end of life care should they be needed.

Is the service responsive?

The service was responsive.

Care was planned and delivered in a person-centred and responsive way.

People were supported to engage with activities they enjoyed.

The complaints procedure was clear and applied when issues arose.

Good ●

Is the service well-led?

The service was not always well-led.

Quality assurance checks had not identified the issues we found at the service.

Staff described a positive culture and values at the service and said they were supported by the manager.

Feedback was sought from people and their relatives.

Requires Improvement ●

Rowan Court

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 21 June 2016 and was unannounced. This meant the registered provider did not know we would be visiting. The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team, Healthwatch and other professionals who worked with the service to gain their views of the care provided by Rowan Court. We received feedback from commissioners, Healthwatch and other professionals who worked with the service.

People using the service had limited verbal communication but were able to communicate in other ways. During the inspection we communicated with three people who used the service. We spoke with two relatives of people using the service. We looked at three care plans, medicine administration records (MARs) and handover sheers. We spoke with five members of staff, including the manager, the area manager, and care staff. We looked at three staff files, which included recruitment records.

Is the service safe?

Our findings

Three people we communicated with indicated they felt safe and happy at the service. Relatives of a person using the service said, "[Name] has a special sleep system and mattress that keeps them safe at night."

Risks to people using the service were assessed and plans put in place to minimise the chances of them occurring. When people started using the service they were assessed in a number of areas, including sleep, nutrition, oral health, medication, moving and handling and skin integrity. Risk assessments were detailed and often included photographs of the person they related to demonstrating how they could be kept safe. For example, one person used a sleep system requiring pillows and blankets to be positioned in a particular way to keep them safe. Their risk assessment, which was produced with assistance from their physiotherapist, contained photographs of the person in bed using the system. This meant staff knew how to help them to bed safely. Another person had epilepsy, and their care plan contained photographs of them having a seizure so staff would recognise when this was happening and know when to assist. The service used recognised tools such as Waterlow and the Disability Distress Assessment Tool to assess risks to people.

However, we saw that risk assessments were not always reviewed by their stated review date. For example, one person had overdue risk assessment reviews on medicines, gastronomy care and choking. Another person had overdue risk assessment reviews in sleep and skin pressure care. A third person was overdue a risk assessment review in nutritional care. From observations throughout the inspection and discussions with staff our judgment was that staff were minimising risks to people using the service but that risk assessments were not being effectively reviewed and updated.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people arising from the premises were regularly reviewed. Checks were made of area including bedroom and water temperatures, beds and electrical equipment. Required test and maintenance were in place, including for firefighting equipment, hoists, legionella and gas and electrical safety.

Plans were in place to support people safely in emergency situations, though they were not easily accessible. Each person using the service had a personal emergency evacuation plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The PEEPs contained a photograph of the person, a guide to their communication and mobility needs and a personal evacuation plan. However, PEEPs were located on the back of people's doors and we asked how emergency services and staff would access these in an emergency requiring immediate evacuation. We were told the service intended to implement a fire "grab bag" next to the front door, and planning for this was ongoing.

There was a business continuity plan in place to help provide a continuity of care in situations where the service was disrupted. This contained details of agencies that could provide support and a description of the

alternate accommodation each person would need.

Accidents and incidents were monitored by the manager and registered provider and steps taken to reduce the chances of them occurring. Two accidents had occurred in the 12 months up to our inspection, both of which involved staff. Records confirmed that the accidents had been investigated and discussions had taken place on how they could be avoided in future. The area manager said, "[The registered provider] have a risk analysis meeting each quarter. Every month we have a risk meeting with the manager."

There was a safeguarding policy in place and staff understood the types of abuse that can occur in care settings. The safeguarding policy contained guidance to staff on indicators of abuse and they should report any concerns they had. There had been no safeguarding alerts in the 12 months up to our inspection, but staff said they would be confident to raise any concerns they had. One member of staff said, "I have had safeguarding training and refresher training. I look for everything, including physical, sexual, neglect and financial [abuse]. I would report it straight away to make sure the person was out of harm." Another told us, "If I had any concerns I would either raise it with the manager or with the chief executive [of the registered provider]. The numbers are on the staff room door." Staff confirmed there was a whistleblowing policy in place and said they would use it if they had any concerns. Whistleblowing is when a person tells someone they have concerns about the service they work for. One member of staff said, "There is a whistleblowing policy in place. I would be happy to use it. Other staff are friends but I don't want friends abusing people."

People's medicines were managed safely. People's medicine support needs were set out in a medicine care plan. These contained details of the medicines they were taking and how they were taken, for example through PEG. PEG is a system used where people having difficulty swallowing foods and fluids. Protocols were in place providing guidance to staff on people's 'as and when required' medicines.

People using the service had their own medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. People's MARs included their photograph, which helped staff to ensure they were administering medicines to the right person. They then listed details of the medicines the person was taking and what they were for. We reviewed three people's MARs and saw they were accurately completed, including staff signatures to show medicines had been administered and relevant coding used when medicines weren't taken. We did note that one person's MAR did not contain their photograph and had some gaps in recording. We asked the manager about this, who said it would be investigated immediately.

Staff had access to a medication policy that contained guidance on how to support people safely with their medicines. Medicines stocks were monitored on a monthly basis which helped to ensure people always had access to the medicines they needed. Where appropriate, medicines were stored in a medicines fridge whose temperature was monitored to ensure they were within safe ranges. The dates medicines had been opened were recorded to ensure they were still safe to use. Controlled drugs were securely stored and regularly monitored. Controlled drugs are medicines that are liable to misuse. This showed us that there were systems in place to ensure people received their medication safely.

We asked the manager how they ensured staffing levels were sufficient to support people safely. The manager said, "As a baseline, when we have 15 people in the building we have 12 care staff. Moving and handling is all two staff to one person, but a lot of aspects of the personal care is one staff to one person. Sickness and holiday are factored into the budget." Day staffing (during the week and at weekends) levels were one senior carer and three care staff on each of the three floors. Night staffing levels (during the week and at weekends) were one carer on each floor and a senior carer working between the floors.

During the inspection we saw that people were attended to quickly and staff were attentive to people in their own rooms and communal areas. Staff told there were enough staff employed to support people safely. One member of staff said, "We have enough staff." Another said, "I think we have enough staff generally. We do have some on long term sick but it's always covered. We do use agency where we have to."

Procedures were in place to minimise the risk of unsuitable staff being employed. One member of staff recalled their recruitment process, saying, "They did DBS checks and references." Applicants completed an application form requiring them to set out their employment history. Records of interviews showed applicants were asked questions based on care scenarios, for example on how they would maintain people's dignity and protect their confidentiality. Two written references were sought, including from a previous employer where possible. Proof of address and identify was sought and Disclosure and Barring Service (DBS) checks carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

Is the service effective?

Our findings

Staff received mandatory training in a number of areas, diversity and equality, the Mental Capacity Act 2005 and DoLS, health and safety, fire prevention, moving and handling, eating and drinking and health and safety. Mandatory training is training the registered provider thinks is necessary to support people safely. Training was based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected.

Mandatory training was refreshed to ensure it reflected current best practice. The manager used a chart to monitor and record staff completion of training. However, when we looked at this we saw that training was not always refreshed in line with the registered provider's timeframes. For example, 10 members of staff were overdue their moving and handling refresher training, 29 staff were overdue their fire prevention training and 18 staff were overdue their infection prevention and control refresher training. The chart also showed that some staff had not received any mandatory training. For example, 15 staff had not received infection prevention and control training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Newly recruited staff completed an induction programme before they could support people without supervision. This consisted of 12 weeks of training, observed care and competency checks by senior carers and the manager. Staff we spoke with confirmed they had completed the induction programme before support people on their own.

Staff were supported through regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff files contained records of supervision and appraisal meetings, and showed that staff were free to raise any support or training issues they had. Staff also completed competency checks in areas such as moving and handling and medicines to see if further training was needed, and we saw records of these in staff files. Staff spoke positively about supervisions and appraisals. One member of staff told us, "They ask how our workload is and I would be comfortable to raise issues." Another said they discussed training in their most recent supervision.

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).

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. Everyone using the service was subject to a DoLS authorisation. The manager kept a chart showing when these had been granted, when they expired and any conditions that applied. This helped ensure that any renewal applications were made in a timely manner. Records confirmed that mental capacity assessments were undertaken where appropriate. Where people lacked capacity to make some decisions they were still encouraged and supported to decide things they were capable of. For example, one person who lacked capacity for some decisions was supported to decide they wanted a flu vaccination and a mental capacity assessment showed they had capacity to decide this. The person had been shown symbols to help them make their decisions. This showed that staff tried different approaches to see whether the person had capacity. Where people lacked capacity to make decisions we saw evidence of best interests decisions made on their behalf.

People were supported to maintain a healthy diet. Some people at the service used PEG to eat and drink. PEG is a system used where people having difficulty swallowing foods and fluids. Where this was the case people's care plans contained details of how they should be supported to use PEG, including how much food and drink they would like through the day and how equipment should be cleaned. Care plans also contained evidence of the involvement of other professionals such as dieticians and speech and language therapists (SALT) to help people maintain a healthy diet. People's weights were monitored and their food and fluid intake recorded to ensure they were receiving enough food and drink.

Each of the three floors at the service had its own kitchen and dining area, and we saw people spending time in these as meals were being prepared. The registered provider had an assistive technology department that helped to customise technology for people to maximise their independence. This had been used to adapt some kitchen appliances so people could help turn them on and off. This helped involve people in food choice and preparation.

Each floor had its own food budget, and people went on a weekly shopping trip to decide how this should be spent. People were also involved in planning a weekly menu, and we saw that people had their own choice of foods in addition to that bought for everyone. For example, one person liked a particular type of breakfast cereal and they bought this on their weekly shopping trips. We observed breakfast and lunchtime during our inspection and saw people were supported with eating and drinking at their own pace and were happy and relaxed.

The service supported people to access external professionals to manage and promote their health. Professionals such as occupational therapists, nurses, speech and language therapists (SALT), dieticians and physiotherapists were involved in developing people's care plans to ensure they effectively met people's health and support needs. For example, occupational therapists were involved in developing safe sleeping systems for people and produced photographic guides to assist staff in using them. This helped to maintain and promote people's health.

Is the service caring?

Our findings

People using the service had limited verbal communication but were able to communicate in other ways. People were able to communicate to us that the support they received was caring and they were happy at the service. People communicated that they got on well with the staff who supported them. A relative of a person using the service said, "The staff are fantastic and the care outstanding."

Staff used Makaton and individually tailored hand, eye and facial expression communication techniques to interact with people. Staff were committed to using techniques that worked best for the person involved. We saw staff using these to communicate with people about their opinions on music that was playing, programmes on TV or what they would like to do for the day. Staff sat with residents while completing paperwork, spoke with them and involved them in conversations.

The registered provider had organised a Skype account for the service, which allowed people to interact with their relatives remotely when they could not visit. Relatives of one person using the service used this regularly, and said, "We find Skype useful as we can see [person's] facial responses to the conversation."

There was a presumption that people could understand what the conversation was about even though they did not always respond, which created an inclusive and homely atmosphere. For example, a member of staff asked a person to tell us what kind of music they liked. The staff member then interpreted the signals the person was making and told us the person wanted to show us the video they were watching on their iPad. In another example, a member of staff asked a person if another person at the service could have one of their yoghurts with their lunch. The member of staff took time to explain what they were asking for, who the yoghurt was for and that they would replace it when they next went shopping. They then waited for the person to think about this and reply.

Throughout the inspection we saw staff treating people with dignity and respect. Staff asked for permission before supporting people and explained what they were doing throughout. We saw staff knocking on people's doors and explaining who it was and why they were coming in before entering, then asking if it was okay for them to do so. Staff worked at people's pace in a relaxing, unhurried manner.

Staff knew the people they were supporting very well and used this knowledge to provide caring support. For example, we saw a member of staff approach someone who had limited vision and gently pick up and stroke their hand to let them know they were there. The member of staff sat next to the person to keep them company as they were watching TV. In another example, we saw a person indicate that they wanted to watch a film after lunch. A member of staff spent time describing their DVDs to them to help them decide what they wanted to watch, and was able to remind the person whether they had seen it before and what they thought of it. Once the person had decided what they wanted to watch the member of staff said they would bring them some snacks to enjoy during the film.

Staff were attentive to people's needs. For example, we saw one person kicking their socks off. A member of staff approached and explained that they would put them back on for them. When we looked in the person's

care we saw the person sometimes kicked their socks off but preferred staff to put them back on. In another example, a member of staff asked permission to wipe a person's face without there being any apparent need to do so. When we looked in the person's care plan we saw they liked to have a clean face and wanted staff to do this.

Staff told us they enjoyed spending time getting to know the people they supported and had time to do so. One member of staff said, "You get manic days but do get time for quality one to one [time]. We can definitely communicate with people here. You get to know people. We break things down and offer choices. It's a process of elimination, sometimes, but you get to know people's routines and get to know people."

At the time of our inspection no one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. There was no advocacy policy in place but the manager was able to describe how they were working with the local authority to arrange an advocate for a person using the service.

No one was receiving end of life care at the time of our inspection. The manager told us how this would be arranged if needed.

Is the service responsive?

Our findings

Care was planned and delivered based on people's assessed needs and preferences. People's care records began with a 'pen portrait' they produced with their families and staff. This had the person's photograph, set out their background and gave an overview of their support needs. There was also an easy read pictorial 'person centred plan', with showing things the person liked. There was then a description of the daily routines the person had so staff knew how to support them throughout the day.

Care plans were then produced on the basis of people's assessed support needs. These covered areas such as nutrition, sleeping, communication, personal care, moving and handling, equipment use and professionals involved in the person's care. Care plans were detailed and person-centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. For example, one person's care plan advised staff that the person liked to have their medicines in bed before they got up for the day so that their stomach had time to settle. They then liked to have their shower at a certain temperature, and the shower setting for this was recorded. Another person's plan contained detailed guidance on how their personal care should be delivered, including a reminder to staff on the order that they liked tasks to be completed in. Care plans were reviewed every six months, and staff said they would be updated sooner if there were any changes to people's support needs.

Daily notes were used to record care and support delivered. This helped ensure that staff changing shift had the most up-to-date information on the person. For example, one person's daily notes contained details of the personal care they had received (including how they had liked their hair styling that day), the activities they had participated in, medicines taken and the fact an eyelash had fallen into their eye so their eye had been washed.

Staff were very effective at communicating with people and using techniques to ensure care was responsive. Staff used Makaton and individually tailored hand, eye and facial expression communication techniques to interact with people. Throughout the day we saw this allowed people to decide what they would like to eat, which room they wanted to spend time in, the clothes they wanted to wear and the music they wanted to listen to. During our inspection we observed an agency member of staff who had not worked at the service before engaging in meaningful communication with people. The member of staff told us, "I was briefed on how to communicate with the people when I started, They are all different. [Name] uses a combination of hand gestures and eye glancing."

The registered provider's assistive technology department developed communication tools specifically tailored to people's support needs. For example, one person had a system in place that allowed them to turn the fan in their room on and off using the internet. Another person liked to use a tablet computer, so a member of staff asked if the assistive technology department could build a holder to position the computer as the person liked it. This had been done and we saw the person was able to comfortably use their computer.

People were supported to access activities based on their preferences and abilities. People had an

individual activities timetable, and these were also displayed in communal areas. Where appropriate, risk assessments were in place for physical activities to help people access them in a safe way. These also included photographic guides for staff of the person taking part in the activity (for example, rebound therapy) so they could be safely supported to access it.

People took part in activities including rebound therapy, sensory therapy, life skills, music technology, speech sessions, hydrotherapy, sensory gardening and sailing. Rebound therapy is a form of physiotherapy. It uses trampolines to provide therapeutic exercises to people with a wide variety of disabilities and additional needs. Photographs of activities were on display at the service, and during the inspection we saw people enjoying sensory gardening and leaving to take part in sailing. One person was able to communicate that they particularly enjoyed rebound therapy and sailing.

There was a complaints policy in place. This provided guidance on how complaints would be investigated and the timeframes for doing so. There was also an easy read 'complaints folder' on display throughout the service. Three complaints had been submitted in 2015 and none in 2016 up to the date of our inspection. Records confirmed that investigations had taken place and outcomes had been sent to those involved.

Is the service well-led?

Our findings

The manager and registered provider carried out a number of quality assurance checks at the service, but these were not always effective at monitoring and improving standards. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We noted that the audits had not identified the issues we found with overdue risk assessments and training. We also saw that recommendations made by the fire service in April 2016 for the management of emergency situations had not been implemented at the time of our inspection.

The manager did not carry out overall checks of the audits to see if they were effectively monitoring standards. They said, "We don't have a central check at the moment. That's something [the registered provider] is working on. I do go and have a look as often as I can, for example if I know the staff who should have been doing the audits have been off." The area manager said, "[The quality assurance officer] is working on centralising all of the audits" and "we are moving towards audits on a monthly basis. It is all being done but it's very hard to see it in overview."

Our judgment was that the quality of the service was not being effectively reviewed and monitored. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff at the service carried out audits of areas including health and safety, temperature checks, hoists and infection control. Where issues were identified action plans were generated to plan and carry out remedial action. The registered provider had a quality assurance officer, who carried out a monthly audit at the service. This reviewed areas including care plans, premises and equipment and staffing levels. This also led to an action plan if issues were identified requiring remedial action.

Staff spoke positively about the culture and values of the service. One member of staff told us, "We try to make it as homely as possible. It's not a care home, it's their home. It's why we don't wear uniforms. It makes it a lot more relaxed and less of a care home." Another said, "We promote independence and give a quality of life." A relative of a person using the service told us, "They provide a home for life."

Staff said they felt supported by the manager, including in staff meetings where they could raise any concerns they had. One member of staff told us, "I feel supported and part of a team. We get staff meetings but I can't always attend. I do try to get to most of them. Everyone has input and we talk about anything that can be improved." Another said, "I feel supported by the manager and we all work as part of a team here." Another member of staff gave a specific example of a time they had raised an issue with the manager and described how this had quickly been sorted.

Feedback was sought from relatives of people using the service in annual questionnaires. The most recent questionnaire had been sent out just before our inspection and had not yet been returned. We look at responses from the 2015 survey and saw they contained positive feedback and suggestions for improvements to the service, such as increased activities provision. The manager said this had been used to

make improvements to the service, and gave as an example increased activities provision. The registered provider also arranged an advisory group with membership from relatives of people using the service, which met every four months to discuss improvements at the service. A relative we spoke with confirmed they were asked to complete feedback questionnaires.

People using the service were not asked to complete a questionnaire but throughout the inspection we saw staff asking how they were. There was an easy to read feedback folder on each of the three floors, containing charts with symbols depicting moods and feelings. This was used to help people give staff feedback.

The manager understood their role and responsibilities, and was able to describe the notifications they were required to make to the Commission.

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 17 HSCA RA Regulations 2014 Good governance The quality of the service was not being effectively reviewed and monitored as issues with training, risk assessments and emergency plans had not been identified. Regulation 17(2)(a). |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had received mandatory and refresher training. Regulation 18(2)(a) |