Prospects Supported Living Limited

Hunters Oak Barn

Inspection report

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Date of inspection visit:
06 April 2016
07 April 2016
11 April 2016

Date of publication:
13 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection of Hunters Oak Barn was carried out on the 6, 7 and 11 April 2016 and the first day was unannounced. The inspection was carried out by two adult social care inspectors. We last visited Hunters Oak Barn on the 4 and 8 June 2015

The service Hunters Oak Barn is registered to provide personal care and accommodation for 12 people who have a mental health diagnosis. The property is a converted barn situated in a rural area of Burnley. Facilities include single occupancy bedrooms, lounge and recreational areas and a swimming pool. There are two bungalow type properties on site for people preparing for independent community living. At the time of our visit there were 2 people accommodated at the home.

During our last inspection we found breaches to legal requirements. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to Regulation 12 and regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to risk management and the skills and deployment of staff to ensure adequate support for people during their mental health recovery, and the management oversight of the service to ensure safe, effective and responsive care was delivered. During this inspection we found the provider had taken action to make some improvements however additional improvements were still needed.

The service was managed by 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.

During this inspection visit we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safety and suitability of premises, safe care and treatment, privacy and dignity, person centred care and good governance. You can see what action we have asked the provider to take at the back of the full version of this report.

We saw good evidence to demonstrate improvements we asked the provider to make in supporting people with staff support to managing risk in relation to self-harm. Risk management intervention plans were in place to ensure people were being supported during critical times in a sensitive manner and in line with guidance in their care plan.

We found evidence that the recruitment and selection of staff had improved and the service followed safe procedures to ensure appropriate staff were employed.

People had their medicines when they needed them and they were supported to manage their own medicines with staff support. We found improvements had been made to make sure staff administering medicines had been trained and their competence level checked before they carried out this task.

People's capacity to make decisions was assessed and by using a mental health recovery star approach to managing mental health care needs this supported people to be self-reliant. We found improvements had been made to make sure staff had formal training provided on the use of the mental health recovery star tool and its application in practice.

People's care and support was kept under review, and people were given additional support when they required this. Referrals had been made to the relevant health and social care professionals for advice and support when people's needs had changed. Health care professionals told us the service followed their plans and worked well with them.

People were cared for by staff who received regular training. We found some improvements had been made regarding staff induction training and supervision.

Staff we spoke with were aware of the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safe Guards (DOLS) and best interests decisions. The registered manager was familiar with the process to follow should it be necessary to place any restrictions on a person who uses the service in their best interests.

The complaints procedure was displayed in the home and we found processes were in place to record, investigate and respond to complaints. People could access advocacy services if they wanted support and advice from someone other than staff.

We noted risk assessments had not included environmental issues in relation to self-harm. We saw records of people barricading themselves in rooms, using ligatures, setting light to papers and attempted suffocation. Actions required following an environmental audit of potential hazards and ligature risk assessments had not been adequately addressed.

We found water temperature monitoring highlighted variances with the temperature at the point of contact and we have made a recommendation about this.

People were cared for by staff with varying degrees of skill and knowledge that meant at times people were at risk of not receiving the right level of support that they might need.

People's privacy was not always respected. People had access to other people's rooms and we saw the management of people's property in their absence was not good. No inventory of their property was taken and we found people's property and possessions in disarray.

People who were considering moving into the home had an assessment of their needs prior to staying at the home. We found their introduction into the service was structured, however we saw one person had not had a full induction to aide them with the move and settling in period in accordance with the service own admission process.

There had been three managers registered with CQC since 2014 which did not provide continuity in leadership at the service. Some issues we found as concerns during this inspection were acknowledged. However the assessment and monitoring of the quality of the service was not robust enough to ensure the safety and wellbeing of people who used the service.

The overall rating for this service is 'Requires Improvement' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Risk assessments around self-harming behaviours had been improved but environmental risks were not managed safely.

There was not always sufficient skill mix of staff deployed to meet people's needs. Recruitment procedures were in place to check staff's character, skills and experience.

Staff had a clear understanding of safeguarding people from abuse and had been trained to recognise this and we found there were suitable arrangements in place to manage people's medicines.

Is the service effective?

Good

The service was effective.

People were cared for by staff that had received mandatory training and were being supervised.

The service was meeting the requirements of the Mental Capacity Act 2005
(MCA) and Deprivation of Liberty Safeguards (DoLS).

People's health and wellbeing was consistently monitored and they were supported to access healthcare services when necessary, and people were supported to manage their dietary needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff spoke to people in a respectful manner, acknowledged their achievements and supported people live fulfilling lives.

People using the service had the support of a key worker who had responsibility for overseeing aspects of their care. This supported a person centred approach taken to meet people's needs.

Staff had training on values based on respect and people's rights to choice, dignity, independence and privacy was promoted, however action had not been taken to make sure people's personal space and belongings were kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People moving into the service were not consistently supported to understand the requirements of the placement and terms and conditions of their residence.

People using the service worked with staff to assess and identify their needs, choices and preferences and plan how they can build a satisfying and meaningful life. They were involved in discussions and decisions about meaningful activities, developing skills and planning for the future with staff support.

Processes were in place to manage and respond to complaints and concerns.

Is the service well-led?

Inadequate

The service was not consistently well led.

The quality of the service was monitored to ensure improvements were on-going. However the number of shortfalls that we found indicated quality assurance and auditing processes had not been effective as matters needing urgent attention had not been fully addressed.

There were systems and established practices in place to seek people's views and opinions about the running of the home, however there was no evidence to show action was taken to demonstrate their views had been considered to improve quality standards.

Hunters Oak Barn

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, 7 and 11 April 2016 and the first day was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed information we had received about the service since our previous inspection in June 2015. This included the provider's action plan, which set out the actions they planned to take to meet legal requirements and any statutory notifications received from the service.

The provider sent us 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.

During the inspection, we spoke with three of the care staff, the registered manager, and the deputy manager.

We looked at a sample of records including care plans, risk assessments and other associated documentation, training records, a selection of staff files, minutes from meetings, medication administration records, policies and procedures and records of audits.

Requires Improvement

Is the service safe?

Our findings

During our comprehensive inspection of the service carried out on 4 and 8 June 2015 we found that risk assessment processes were not robust enough to ensure that all risks associated with self-harming behaviours had been identified. It was also found that the staff providing support for people had not been adequately trained. The approach taken to dealing with risk of the staff team had led to people using the service being left to manage with the consequence of their self-harming. There was a lack of clear direction as to when staff should intervene and offer support.

This was a breach of Regulation 12 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan. We received an action plan from the service provider advising us that improvements would be made by 1 October 2015.

At this inspection we noted some improvements had been made. Staff training records identified new staff had received initial basic two hour training sessions in topics such as personality disorders, eating disorders and mental health awareness.

Risk assessments had been completed in relation to supporting people who self-harmed. Staff were aware of situations that could pose a risk to people and of the potential triggers and indicators of relapse in people's mental health wellbeing. Information recorded detailed triggers or signs that could indicate individuals were becoming anxious or unwell. There had been improvements in managing risk whilst working with people using a recovery star tool approach to support their recovery. Constructive risk taking was supported by risk management intervention plans and people were being supported during critical times. We found recorded evidence of instances to demonstrate staff had acted in line with guidance and followed the correct procedures in supporting people.

We noted however risk assessments had not included environment issues in relation to self-harm. We saw records of people barricading themselves in rooms, using ligatures, setting light to papers and attempted suffocation. We had also received notifications at the CQC relating to people cutting themselves. This meant when people where time was important to support people for example who had self-harmed, access to their room would be difficult.

We found the provider had carried out their own environmental risk assessments but were unable to produce a risk assessment for their swimming pool and their main hall/atrium. During our inspection we noted that the atrium contained areas where people would be able to secure a ligature to. The provider had also noted this and made some alterations, for example they had covered ornamental metal bannisters in Perspex so they could not be accessed. However they had not covered all of the bannisters and the covers they had provided were not fit for purpose as they only covered on side of the bannister and did not encase the rails fully. .

According to the environmental risk assessment we were shown this had highlighted that 'risk assessments do not cover all hazards in all areas and we feel they should be reviewed by a competent person' and 'there

should be more detail in the risk assessments with regard to self harm'. These were completed some time later by the Nominated Individual [NI] and a list of 31 potential hazards, including possible ligature points had been identified in March 2016. Of those only six had been rectified. The others were recorded as to be done in '6-8 weeks'. We noted that the NI had failed to identify or rectify any hazards to people barricading themselves in their rooms and possible harming themselves. Incident reports we looked at showed this had happened recently which had resulted in people carrying out acts of self-harm and setting fire to papers. Simple strategies to minimise risk had not been employed. During our tour of the building we also noted other potential ligatures such as electrical cords which had not been recorded in the providers risk assessment.

We found window restrictors had not been fitted in all rooms and removable voile nets were arranged on window poles. The NI's risk assessments for ligatures stated that some fixtures (curtain poles, showerheads) were non load bearing. There was no evidence that any load bearing tests had been carried out. The registered manager acknowledged this and tested and removed these during our inspection.

We saw that some people's bedrooms had two access and exit points. Some people who used the service were able to access other people's bedrooms as the service did not have a system of locks on doors to enable them to secure empty rooms. We had received a notification from the service of an incident when this had happened. One person had been assaulted in their room whilst in bed by another person living in the home. Some 'empty' bedrooms were being used as storage for people who had previously used the service. These were noted to be disorganised and people living in the home could easily access these areas and secrete objects or medication with which to harm themselves. We noted two incidents had occurred in the loft space that made it difficult for staff to access. Following this the registered manager had screwed the door to its architrave preventing access altogether.

We spoke with staff who told us they carried out daily security checks. The staff member allocated this duty on the day of our inspection told us there were no issues on the morning of our first day of inspection. However we noted that whilst looking around the home that there were razors left unattended in two showers, one of which was accessible from a communal area. When we spoke to the NI she acknowledged that these should have been removed and stored securely.

Part of a strategy of keeping people safe in the home was to observe their whereabouts and behaviour on a regular basis. When we arrived at the home we found no-one was under observation and therefore observations were not being recorded. This was despite daily records maintained which showed some people who used the service displayed upset, agitated and aggressive behaviour on the days leading up to our visit.

The NI told us that they had CCTV to monitor 'black spots' in the home but acknowledged that no-one was watching it. We asked the registered manager if they had a policy and procedure for the use of CCTV staff would know about. We were told, "Not as yet." There was no record of the steps taken when deciding to use surveillance.

We recommended the registered provider follow guidance issued by the Care Quality Commission in relation to the use of surveillance equipment and develop a policy statement and procedure to support its use.

We looked at water temperature monitoring checks. We could see there were variances in temperatures ranging from 23.9 Celsius – 61 Celsius. Furthermore one person using the service told us at times their room was very cold and they wore a dressing gown over their clothes to keep warm.

We recommended the registered provider seek guidance from a reputable source on managing risk from hot water and surfaces in health and social care.

We found the service did not responsibly act on the results of environmental risk assessments in place to consider the actions of people who were at risk of self-harm by means of ligature. Therefore the service had failed to implement the necessary adjustments and adaptations required to the premises to enable safe care and treatment to people who displayed this type of self-harming behaviour. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From records we looked at relating to self-harm and from discussions with the registered manager and staff on duty, there were times when staffing arrangements were not sufficient in providing people with the level of supervision they needed. Staff we spoke with told us sometimes when there was only two staff on duty, this was difficult during critical times when serious incidents needed managing and quite often involved more than one person using the service. We were told the problem was evenings and weekends. Information we received from the service before this inspection indicated staff dealt with significant issues during this time frame.

We saw a record of debrief carried out with a staff member following an incident they had been managing. They indicated the incident could have been managed better if an experienced staff had been present. We were told by staff that in the evenings and at weekends there was two staff on duty. There was occasions when two members of staff were needed to support people in accordance with their risk assessment, but this was not always possible. This meant staff safety had not always been considered.

We noted a member of staff was moved to another service to cover a shift. The registered manager told us sometimes staff from other homes within the company covered shifts and they covered shifts at other homes. People we spoke with told us this was not ideal. This was because staff who occasionally worked in different homes did not know the people they were supporting. One person using the service told us, "I don't like having different staff, I don't know them and they don't know me." We relayed this to the registered manager who acknowledged this concern and said, "It happens sometimes when an emergency crops up." We were also told by the registered manager they were currently recruiting new staff which should minimise the need for this practice.

We saw another debrief where a staff member indicated the situation could not possibly have been managed with two staff. We looked at the duty rotas and found that on the day of the incident two staff members were on duty until 8pm and two staff members on night duty from 8pm until 8am the following day. On the following day the numbers of staff on duty was the same, but during the day there was no senior staff member identified on the rota. We did not see any evidence to show that a systematic approach to determine the number of staff and level of skills, supervision needs and leadership requirements had been applied. This meant staff was reliant on telephone support in very difficult situations until the senior delegated person on call, made a decision whether to offer advice or visit the home to support them when a critical incident occurred. By failing to make sure there was sufficient numbers of staff deployed with the right skills and competence and in sufficient numbers to cover emergency and routine work meant people were potentially at risk of not receiving the right support in emergency situations.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last visit we found there was an improvement in skill of staff deployment for emergency first aid. Duty rotas identified a delegated first aider on duty when the registered manager and registered nurse

finished their shift and this included weekend.

We looked at the recruitment records for three members of staff. We found appropriate checks had been completed before staff began working for the service. These included the receipt of a full employment history, written references, a record of interview, an identification check and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. One new member of staff told us they did not commence work until all the required recruitment checks were in place.

Staff told us they had received safeguarding vulnerable adults training. Records confirmed most staff had received appropriate training within the past two years and additional training had been booked. The staff we spoke with had an understanding of abuse and were able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. They were aware of their responsibility to ensure concerns were reported immediately and were confident the registered manager would deal appropriately with any concerns they raised. The registered manager was clear about their responsibilities for reporting incidents and safeguarding concerns and had experience of working with other agencies dealing with these issues. Information we held about the service indicated any safeguarding matters were appropriately reported to the relevant authority.

We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. We saw that people's current medicines were confirmed on admission to the home. Medication was delivered pre packed which meant people's medicines had been dispensed into a monitored dosage system by the pharmacist and then checked into the home by staff on duty. Corresponding Medication Administration Records (MAR) charts were provided and all the MAR's we checked were complete and up to date.

There were arrangements in place to make sure people had their medicines when on home leave. These were delivered by the supplying pharmacy in a monitored dosage pack. This reduced the risk of people having access to more medicines than were required for their leave.

Medicines were stored securely which helped to minimise the risk of mishandling and misuse. A designated room for the storage of medicines was kept locked and staff on duty had access to the keys. Medicines were stored in locked cupboards and staff checked medicines every morning before administration. Appropriate arrangements were in place for the management of controlled drugs which were medicines which may be at risk of misuse.

Staff also monitored medicines people using the service purchased that could cause harm if taken in excess. Staff maintained a record of these medicines handed in to them and when they were returned to the chemist for disposal. Training records showed staff responsible for medicines had been trained. Regular internal and external audits of medicine management were being carried out. This helped to reduce the risk of any errors going unnoticed and enabled staff to take the necessary action.

Good

Is the service effective?

Our findings

During our comprehensive inspection of the service in June 2015 we found that not all staff supporting people had received adequate training to equip them to be skilled and competent to care for those people who had complex needs associated with self-harming behaviours. Some staff had not received first aid and risk assessment training to ensure that they were skilled to deal with any emergencies. Furthermore the training staff received in other topics was minimal and had been via electronic learning without competency checks to ensure the level of understanding was acceptable. We had made a recommendation regarding this.

We received an action plan from the provider advising us that improvements would be made by 1 October 2015.

At this inspection we found that the provider had followed their plan and had made a number of improvements. We were given copies of all the staff team training records. These showed staff had received essential training. Some of the training had been e-learning. Other certification of training seen on files included evidence of two hour sessions on topics such as borderline personality disorder, self-harm, eating disorder, mental health awareness, health and safety awareness and control of substances hazardous to health (COSHH). We could see that where people had not demonstrated a competency level for example with incident reporting, they had been required to undertake further training.

We could see from the training records that staff supervision had identified further training needs. These included for example equality and diversity, mental health awareness, eating disorder, manual handling, recovery star, self-harm, and infection control. When training needs were identified this meant staff had been assessed as requiring further knowledge. We saw that training had been planned to cover the topics identified. However we found some staff had not received formal supervision since October 2015 and some identified training was planned for April 2016 showing a gap from identification of training needs to training delivery. The registered manager told us why this had not been completed along with an action plan going forward to address this. This meant staff might not necessarily be following best practice or guidance when supporting people.

Staff we spoke with told us they had received training relevant to their role. One staff member told us, "We've done on line training. We seemed to do a lot around Christmas." Staff generally considered they received the training they needed but considered face to face training rather than e-learning was the most useful.

We spoke with a newly recruited staff member in the process of their induction. We observed them reading policies and procedures during two days of our visit. They told us "I'm going through the policies and procedures and doing e-learning. Anything I'm not sure of, I can ask the manager or staff. I've had some practical training for ligature removal."

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). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.

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. At the time of the inspection none of the people using the service were subject to a DoLS. Staff we spoke with showed an awareness of the need to support people to make safe decisions and choices for themselves. They had some understanding of the principles of these safeguards and had received training on the topic.

Care records we viewed showed people's capacity to make decisions for themselves had been assessed before they stayed at the home. The registered manager told us people currently using the service were not subject to compulsory measures under the Act. The service used a mental health recovery star approach to support people to manage their mental health care needs that involved decision making. The mental health recovery star is underpinned by a five stage model of change leading to self-reliance. We found there had been improvements made since our last inspection in how the service applied their support for people who did not always make good decisions particularly around self-harm incidents. Staff we spoke with told us, "We encourage people to make good choices. They don't always take our advice but we work with them and provide the support they need during critical times." And "We work with people and give them advice particularly when they are unwell and need further treatment. The choices they make are not always good ones but we stay with them and offer our support."

We saw that the service co-ordinated their support for people with health and social care agencies involved in people's continuing health care. People were registered with a GP and had access to a range of healthcare services. We spoke with two healthcare professionals visiting people using the service. We asked them to comment on how the service worked with them to support people in their care. They told us they liaised with staff. If there were any specific actions they required they would write this down in the communication book. Psychological formulation meetings were being carried out to support people address the cause and effect of their problems and find a resolution with the right support. Staff we spoke with told us these formulation meetings were very good as they helped them understand better why people behave the way they do, and as one staff said, "It opened my eyes."

We looked at how people were protected from poor nutrition and supported with eating and drinking. A staff member told us each person had a budget of £40 allocated from the company to purchase foods of their choice. As part of their rehabilitation they were supported to plan menus, shop for food, prepare and cook meals and if they wanted did baking. We observed one person cooking a meal at lunch time and the food cooked was appreciated by all who sampled it. We were told by staff people were encouraged to eat healthy food and support was provided with cooking and baking lessons. Staff we spoke with told us they had training in eating disorders.

Requires Improvement

Is the service caring?

Our findings

We observed people had one to one psychotherapy sessions in the dining room. There was no signage used to indicate a private meeting was in progress. We spoke with the registered manager who told us they had plans to create a therapeutic room for this purpose.

We looked around the premises and found privacy was an issue for people. We found bedroom doors did not have safety locks fitted as standard. We were told by the registered manager this was for safety reasons as access to rooms was essential. We noted two bedroom doors had been removed due to people barricading themselves in their rooms which had placed them at increased risk of not getting the support they needed in a timely manner. We were not shown any evidence that alternative solutions had been explored and considered. We also noted link doors between bedrooms had not been locked which meant people could access these adjacent rooms if they chose to without permission.

Two rooms previously occupied by people using the service had their personal possessions stored since they had left the service. One person had been discharged in an emergency situation. How their possessions were left did not show respect for their personal property. There was no inventory record made of people's property and it was concerning to see items of unwashed clothes on the floor and people's clothing and possessions in disarray. We discussed this with the registered manager and on the second day of our visit, some improvements had been made.

We judged the service was failing to ensure each person's privacy was maintained at all times. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw quality monitoring questionnaires people had been completed regarding the support they received whilst living at Hunters Oak Barn. The results of this indicated confidentiality of personal information about people needed to improve. They said, "Sometimes confidentiality doesn't feel like it is in place or as good as it should be." And "You can open up to a member of staff and then they go and tell everyone what you told them. How are you supposed to trust when it is constantly being abused?" This resulted in people not always feeling they were respected or valued. We discussed these comments with the registered manager who told us they took a serious view on any breach of confidentiality. They said, "Staff know the terms and conditions of their employment regarding this." We also discussed the benefit of reminding people at the start of their engagement with staff, the reason and importance of the sharing of information to support them in their recovery.

People also commented in the quality monitoring survey certain staff attitudes needed to improve and when asked if 'staff listens to you' the response of one person was 'depends on the staff'. We did not see any action plan that addressed the comments people had made. There was an indication during our visit people did not like seeing new staff. One person's 'trigger' for self-harm was 'not having regular staff on shift'. We discussed this with the registered manager who said people liked consistency when it came to the staff who supported them. They were currently recruiting staff to avoid using staff from other locations with the company.

During this inspection we observed how staff interacted and related to people using the service. They spoke to people in a respectful manner and acknowledged people's achievements. For example one person was moving towards independent living and was preparing to move into a step down facility with staff support. Staff were quick to praise efforts with cooking and focused on the person's achievements to date and plans they had for the future.

Staff we spoke with were knowledgeable about people's individual needs, backgrounds and personalities. They discussed how they provided people's support and promoted their rights and choices.

Staff we spoke with also told us how they worked alongside people using the mental health recovery star program, supporting them to develop their individual recovery-focused plan. This involved people taking control with their journey to recovery and at a pace that suited them. They had regular meetings with people they supported as key worker. Staff also spoke with enthusiasm about the 'formulation meetings' which were being undertaken by a psychologist who had recently been employed by the service. Staff said these had given them a better insight into people's life experiences and an understanding of their needs. We saw evidence that people using the service had regular meetings with their key worker. They were supported to express their views and reflect on their experiences.

There was a 'keyworker' system in place. This linked people using the service to a named staff member who had responsibilities for overseeing aspects of their support. The registered manager told us people's views were taken seriously and people could choose their key worker. Staff told us they had regular meetings with people they were key worker to.

Information was available about the service in the form of a service user guide. This provided an overview of the service and facilities. When people moved into the service they were given a copy of the service user guide which included all the information they needed to know. Access to advocacy services was available if people wanted support and advice from someone other than staff.

Requires Improvement

Is the service responsive?

Our findings

We looked at how the service ensured people using the service had their care and support that was personalised specifically for them. The registered manager described the service's referral and assessment process. This involved gathering information from the person and other relevant sources, including the persons care co-ordinator, social worker and psychiatrist.

We looked at the assessment records of the person most recently admitted and found they covered a wide range of needs, abilities, choices and behaviours. Once all parties had agreed to the placement an introductory period of time was spent at the home was offered. This provided the person with an opportunity to meet with staff as well as other people living there. It also provided staff with an opportunity to prepare for the persons stay and produce a transitional care plan that would support them during this time.

We were told people's admission to the home was planned. People were given an induction to the service to be completed within 0-8 weeks of the placement. We saw records staff were required to complete to confirm all aspects of people's care and support needs was explained to them. People living in the service were required to read, discuss and sign their service user agreement, disclaimer notification, and photo consent and to read and discuss house rules. However in the care file we looked at we saw that the induction documentation had not been completed other than GP registration and change of address. We could not establish whether the person had understood the requirements of their placement and a number of recurring incidents showed the person was not cooperating with any agreement regarding how they conducted themselves, and was presenting behaviour of increased risk of harm to self and others.

This is a breach of regulation 9 (1)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at people's care plans. We found these were comprehensive and reflected the complexity of people's needs. We were told Registered Mental Nurses (RMN) role was to formulate people's care plans. It was evidenced from the duty rotas dating back to January 2016 that RMN's actual time spent in the home was minimal. On call arrangements showed RMN's on call alternative weeks which meant that there was little evidence to confirm that they provided any leadership in ensuring people under their care were safe during this time. The NI told us after the inspection RMN's are present for the amount of commissioned hours per week.

Records however showed people were encouraged to work through their mental health recovery star tool with the support of staff. This took into account their mental health needs, physical health and self-care living skills, social networks, work, relationships, addictive behaviour, responsibilities, self- esteem and trust and aspirations. We found improvements had been made since the last inspection. We saw that better arrangements to respond appropriately and in good time to peoples presenting and complex needs and risks had been made with strategies in place for staff to support people when they became unwell.

Staff described how they delivered support in response to people's individual needs, abilities and preferences. Staff were able to discuss the progress people had made in their recovery and rehabilitation programme. One person told us they were moving into the 'step down' accommodation and although they felt anxious, they were being supported by staff.

One person we spoke with told us they were involved in discussions and decisions about the type of activities they might like to take part in. We saw staff spending time talking to people and joining in activities. Staff would plan for the week ahead with people and provide structure for daily living. We saw that these plans could be changed at any point should the person decide to do something different. People told us they went shopping, prepared and cooked meals, baked and had shared responsibilities for household chores and did their own laundry.

We found positive relationships were encouraged and people were being supported as appropriate to maintain good contact with relatives and friends and 'home leave' was planned for. This meant the risks of social isolation and loneliness were less likely to occur. Public transport timetable and information about local taxis was displayed in the home.

There was a range of ways for people to feed back their experience of the care they receive and to raise any issues or concerns they may have. This was done through annual service user surveys, recovery star model of care that involved one to one meetings with staff, positive risk taking, formulation meetings and residents meetings. We noted however there was no report of actions completed as a result of people's comments.

The complaints procedure was displayed in the home and the service had policies and procedures for dealing with any complaints or concerns they received. We found processes were in place to record, investigate and respond to complaints.

Meetings were held every month with other agencies directly involved in people's care to discuss their progress. People had a transfer of service pen profile completed. This contained essential information other services would need to know to help support people receive continuing care, and to support their movement to another service.

Inadequate

Is the service well-led?

Our findings

There was a manager in post who had been registered with the Commission at Hunters Oak Barn on 5 August 2016. There does not appear however, to be stability within the management of the service as three different managers has been registered with CQC since 2014

At our last inspection we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because improvements were needed in risk assessment and management of risk, staff deployment, training and supervision.

We received an action plan from the provider advising us that improvements would be made by 1 October 2015. During this inspection we found that whilst some improvements had been made in staff training and support provided to people when they were unwell, there were further improvements needed.

We discussed the findings of a Health and Safety audit commissioned by the service and carried out on the 19 November 2015 and 8 January 2016, with the registered manager and NI. The provider had been made aware of these risks in January 2016. The audit was clear regarding risks and provided the registered provider with the level of risk identified as low, medium, high and any actions required. A further risk assessment was carried out on the 4 March 2016 by the NI regarding ligature point risk assessment. We found the response to the findings of these risk assessment was not good in ensuring people's welfare and safety. Out of 31 potential hazards only 6 had been rectified although the provider had been made aware of these risks in January 2016.

The registered manager used various ways to monitor the quality of the service. However despite quality auditing systems or processes to assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others, the registered provider had not taken appropriate action in a timely manner to improve the service. This meant the registered provider was not always responding appropriately to make sure people using the service receive safe and effective care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found some improvement around management in supporting people where risks to themselves and others had increased. This was because monitoring of this had improved in the way people were being supported by staff in in dealing with self-harm in a more caring way such as escorting people to hospital.

Whilst quality monitoring was taking place with people who used the service and staff, there was no action plan completed as a result of their comments. This did not support people to have confidence their view mattered and issues they raised would be addressed. However one person using the service had commented, "If it wasn't for Prospects I don't know where I would be today."

People told us if they had any concerns regarding staff they could report this. We were told people using the

service were actively involved in the selection of staff and were able to give feedback on staff performance that was linked to staff supervision. This meant there was some oversight on staff performance. However we did not see any evidence of this.

We looked at the result of a quality monitoring survey completed by staff. The main issue they identified for improvement included improving communication. Staff implied they had good support from management and good training. However a comment was noted "I feel massively supported but not valued." We discussed this statement with the registered manager. We were told all staff were valued. Different reward systems had been implemented in the past such as employee of the month and gift vouchers. The registered manager was unsure why this had stopped but told us staff had access to opportunities for promotion within the company, training opportunities and opportunity to take more responsibility in particular areas of their work.

Two healthcare professionals we spoke with told us they have seen improvements over the past few months. This was related to improved communication. They told us staff were very caring and the management of the service receptive to suggestions they made.

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 9 HSCA RA Regulations 2014 Person-centred care The provider has not made sure a person's view regarding their planned transfer or their understanding of the requirements of their placement in relation to the terms and conditions of residence were established.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider has failed to ensure people's privacy and dignity was maintained at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has not made sure there was sufficient numbers of staff deployed with the right skills and competence and in sufficient numbers to cover emergency and routine work meant people were at risk of not receiving the right support in emergency situations.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because the registered provider had failed to implement the necessary adjustments and adaptations required to the premises to enable safe care and treatment to people who displayed self-harming behaviour.

The enforcement action we took:

issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider has failed to take action in a timely manner to improve the service and make sure people using the service receive safe and effective care.

The enforcement action we took:

issued a warning notice