Nexus Programme Limited

The Hall

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 31 March and 1 April 2016 and was unannounced. The Hall provides accommodation and support for up to 10 people who may have a learning disability or autistic spectrum disorder. At the time of the inspection eight people were living at the service. Within the service was a communal lounge, dining area, kitchen, shared bathrooms, and a laundry room. People had access to a courtyard garden where there was a small outbuilding which people could use to play video games and do other activities. The Hall was last inspected on the 28 April 2014 and no concerns or breaches of Regulations were identified.

Although a manager was registered with the commission they no longer worked at the service. A new manager had been appointed who was present on both days of the inspection; they had applied for registration with the Commission. 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 home was also registered to provide a supported living service but we were told by the registered manager of this service that this had not been started as yet although there were plans to do so in the future.

There were insufficient staff on shift during the night to support people and keep other people safe. People were requested to go to bed and get up at specific times to minimise the risk of harm.

Recruitment processes were not safe as staff recruitment files lacked information which is required by the Health and Social Care regulations. This included photographs, exploration into employment gaps, reasons for the termination of previous employment, criminal checks and suitable references. This was putting people at risk of receiving care from inappropriate staff.

Risk assessments were not always followed by staff, did not reflect the current needs of people, or were missing. This left people at risk of harm.

When people were prescribed occasional medicines it was not documented how staff would be able to identify when the person required their medicine. One person had been administered occasional medicine without clear protocols in place. Not all medicines were stored safely.

Some staff had not fully completed their in house induction before working without supervision. When areas of concern around staff conduct had been raised evidence of follow up supervision or observation was missing. Some training had lapsed or had not been completed.

Some capacity assessments had been made following the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. The provider had failed to notify the Commission when authorisations had been granted by the supervisory body which is a requirement of the regulations. People had access to

advocacy service if they requested or needed this.

There was an inconsistency in care plans and behaviour guidelines. Some contained detailed guidance for staff about how to support people, but others lacked this necessary guidance.

Internal audits had not been successful in identifying the shortfalls found at this inspection. Since the acting manager had taken up post there had been some improvement in areas of the service and acting manager had made plans to further improve the service people received.

Staff had a clear understanding of how to recognise and report safeguarding concerns and knew who to contact and how. Staff understood how to whistle blow and had access to numbers that they could phone in confidence to report concerns.

Staff were in receipt of supervision to support the development of their role and could attend staff meetings.

People had choice around their food and drink and were encouraged to make their own choices and decisions about this. If people declined their meal, an alternative was offered.

The service was good at responding to people who needed help to manage their health needs. People were supported to access outside professionals and the service was adaptable when a person's needs changed.

When people moved between the service this was completed in a thoughtful and person centred way. Positive steps were taken to ensure people were placed appropriately.

People knew how to complain, when complaints had been made these had been responded to appropriately.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff deployed throughout the night to keep people safe. Restrictions had been placed on people's movement to reduce the risk of harm from behaviours other people could display.

People were supported by staff, who had not been assessed as suitable for their role.

People were not kept safe as assessment of risks were missing or were not being followed.

Storage of medicines had not followed the providers own policy.

Staff understood the processes for raising concerns about people and knew how to whistle blow to protect people from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received all the training they required to meet people's needs. Some staff had not fully completed their induction before working without supervision.

Authorisations to deprive people of their liberty had been made but the provider had not notified The Commission about the outcomes of the authorisations granted.

People had choice around their meals and staff supported people to manage their diets and make healthy food choices.

People were supported well with their healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some areas of practice restricted how people chose to live.

Staff spoke to people in a respectful and engaging way and there was good rapport between people and staff.

Staff cared about the welfare of people and adapted to their changing needs.

Staff were respectful of people's private space and asked for permission before entering their bedrooms or engaging in conversation with them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were inconsistent and some lacked enough detail to inform staff how they should consistently respond to people's individual needs.

People were supported well when moving between services. The service only offered a service to people who they had assessed as being able to meet their needs.

People had access to a complaints policy and knew how to complain. Complaints were responded to, to improve outcomes for people.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Internal audits and quality monitoring had failed to identify the areas of concern identified at this inspection.

People were asked for their feedback about the service they received, but action taken when concerns were raised were not documented or evidenced.

The acting manager had made some improvements to the service and had planned further improvements they were working towards.

The Hall

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 the 31 March and 1 April 2016 and was unannounced. The inspection was conducted by two inspectors on the first day and one inspector on the second day. Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. We reviewed the Provider Information Return (PIR) and used this information when planning and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The acting manager was also asked to send us some further information after the inspection, which they did in a timely manner.

During the inspection we spoke with six people, six staff, a visitor, the acting manager, a senior manager and the provider. After the inspection we spoke to three relatives by telephone, we received responses from three healthcare professionals. Not all people were able to express their views clearly due to their limited communication, others could. We observed interactions between staff and people. We looked at a variety of documents including peoples support plans, risk assessments, daily records of care and support, three staff recruitment files, training records, medicine administration records, minutes from staff meetings and quality assurance information.

Requires Improvement

Is the service safe?

Our findings

One person said, "You can stay up later on Friday and Saturday but earlier other days. I don't mind, I get tired". Another person told us, "I like it here, I feel safe". There was not enough staff deployed to allow people to have choice and freedom in the way they lived. The acting manager said, "To safeguard people we have imposed the bedtime rule". The service had adopted a blanket approach to minimise the risks to people's safety due to some of the behaviours people could display. Specifically, this was happening during the night. A community living agreement stated: 'Staying up routine weekdays: Sunday to Thursday 10.00pm is the time you are requested to go to your rooms. Friday and Saturday 12.00am you are requested to go to your room, but no falling asleep in the lounge!!'. This agreement had been signed by the people living at the service. Asking people to go to bed early to protect them from the behaviours others could display was not the least restrictive option available and was not a person centred or a respectful approach to people's individual needs. There had been an incident where a person had refused to go back to their room during the night. They had been asked to return to their room by staff which resulted in an incident of aggression towards the staff member. An incident report stated the person had "disregarded the house rules when instructed". The night protocols for this person said that if the person came downstairs in the night they were to be reminded of the house rules, to be in their bedroom by 10.00pm and they should not come down in the morning until 08.00.am, this demonstrated institutionalised practice.

The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to fully meet people's needs. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the day sufficient staff were available to meet people's immediate needs. Staff had time to offer people support in an unhurried way, and spent time interacting with people at a pace that suited them. On the first day of the inspection the service was operating with one wake night and one sleep in staff. This increased to two wake night staff from day two of the inspection as a new person was moving into the service. From 8:00am until 10:00pm there was a minimum of five care staff available. This included a team leader and senior care worker. Agency staff were not used at the service and the acting manager and a senior manager would cover shifts if short staffed. A housekeeper was employed four days a week from 10:00am until 4:00pm; their duties included cleaning and cooking meals which meant other staff had more time to spend with people to meet their individual needs. Two maintenance people were employed by the company who split their time between this service and the other services in the organisation.

People were not protected from robust recruitment procedures. From the three staff recruitment files viewed all three were missing reference checks, two were missing photographs, identification and employment history exploration and one was missing a Disclosure and Barring Service (DBS) check. DBS checks identified if prospective staff had a criminal record or were barred from working with adults. One staff member had not disclosed information about a caution they had received and this had not been followed up by the provider. The provider had not acted or were not able to demonstrate how they ensured staff were suitable to support the people in the service. This was leaving people at risk of harm because the provider had not taken all the appropriate checks to ensure staff were suitable for their role.

The lack of effective and safe recruitment processes is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some risk assessments did not reflect the current needs of people, were missing or not being followed. 70 litres of fabric conditioner and liquid washing detergent were left in the laundry area which was unlocked and accessible to anyone. One person's risk assessment stated they had historically drunk cleaning material and this was an area that needed to be manged to safeguard the person from harm. We raised this concern with the provider and cleaning material was relocated to the designated safe storage area. Potential risks were not always identified; one person was starting a new job the following day which they would be attending alone. Currently they were being supported one to one whilst out due to deterioration in their behaviour. A risk assessment had not been implemented for them attending their job alone which posed a risk to the person and other people.

The provider had failed to do all that was reasonable practicable to mitigate risks. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of the service were in need of decoration, repair and were unsafe. A bedroom where a person was due to move into shortly had a skylight window that was not fitted with a restrictor to prevent the window from being fully open. This window posed a risk of falls. Some fire doors were not meeting the required standards of safety and were missing self-closing devices and Door guards. A Doorguard safely keeps a fire door open and will self-close if the fire alarms are activated. One person's fire door was being propped open with a rug instead of a Doorguard or similar safety device. This was not keeping people safe from harm. Paving slabs were loose in the court yard which posed a risk of trips and falls. Several unguarded portable heaters which would be hot to touch had not been guarded or risk assessed to minimise the risk of people burning themselves. Some safety checks had been missed including monthly emergency lights and drills and weekly fire alarm. This meant that the provider could not be certain that safety equipment was in good working order to be used in the event of a fire.

There was a maintenance plan in place to improve the service, but the service was not proactive in ensuring that the premises were maintained. Maintenance personnel said, "It's a big job, there's loads to do outside and inside the homes, we prioritise". Carpets on the staircase were ripped in places and looked unsightly, although they did not pose a risk of trips. The boiler was behind a broken cupboard and was accessible to anyone and therefore people were at risk of scalding themselves. There was some water damage to ceilings and walls which looked unhomely and did not maintain a dignified environment for people.

The provider had not ensured the premises was safe for people to use, had not provided appropriate equipment to mitigate the risk of harm to people and safety checks were inconsistently completed. This is a breach of regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a maintenance plan in place to improve the service. On the second day of the inspection the maintenance personal visited to repair the loose slabs in the courtyard and dispose of rubbish. Bathroom facilities had been improved recently with the installation of a new bath and shower.

Six people required support to take prescribed medicines. All medicine was stored in an office in a lockable medicine cupboard. Guidance was missing to inform staff when people would require occasional medicines (PRN). One person had been prescribed medicine to help them manage their behaviour. Guidance was conflicting and unclear as to how much the person should receive in a 24 hour period. Guidelines in the medicine folder stated no more than two tablets per 24 hour period but the handwritten entry on the actual medicine administration record (MAR) sheet stated no more than three per day. Guidance lacked

information about how staff could recognise if the person required this medicine. This was confusing for staff, and could result in the incorrect dosage being administered. The person had received their PRN medicine on a number of days, sometimes twice in one day. Daily records and behavioural incidents did not record the person had been having difficulties with their behaviour and there was no clear reason why staff had administered this medicine. We asked the acting manager why this was happening and they were unable to give us a valid reason. They told us that they had been advised by a health care professional to give PRN to the person if they were upset or frustrated, but there were no evidence to verify this was the reason why the person had been receiving this. One staff told us they would "judge it" when the person was in need of this medicine. This practice was not following the providers policy which states, 'Staff administering PRN medication must ensure the medication is given as intended by recording a specific plan in the residents support plan which should be kept with the MAR chart'. Another person was prescribed pain relief medicine as a PRN; there was no description of how the person would communicate if they were in pain meaning this person may not receive their medicine when they needed it.

Audits logs were being used to ensure that medicines were all accounted for, but systems had failed to ensure safe practice was followed. During the inspection several medicines were unaccounted for, after the inspection we were informed that the missing medicines had been stored in the manager's office waiting to be returned to the pharmacy but this had not been communicated to the person in charge of the medicines. This was not following the providers own policy which stated, 'Medications must be stored in safe place. There will be adequate storage facilities to ensure all medications are stored correctly and that no medications will be stored on the floor'. Records of the medicines being 'booked out' were missing which is part of the providers safe practice system. Poor systems of storing and recording medicines could impact on people safety as doses could be missed or medicines used inappropriately. A person's prescribed cream dated 2013 and ear drops had been left on top of the first aid cupboard in the senior's office. This was not following the provider's policy about returns of unrequired medicines. Staff told us this needed to be returned to the chemist and moved them back to the locked cupboard to store safely. New medicine received had not been recorded on the MAR chart appropriately following good practice.

The provider had failed to have proper and safe management of medicines; this is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of their responsibilities in relation to keeping people safe. They knew how to whistle blow and report any concerns to their manager and also to external agencies such as the local safeguarding team or The Commission. Staff were able to describe how to raise safeguarding concerns and who they could report concerns to outside of the organisation. The service had made appropriate referrals and notifications when safeguarding concerns had been reported.

Requires Improvement

Is the service effective?

Our findings

Some staff training had lapsed or had not been completed. This meant people were not supported by staff, who had the most up to date knowledge and skills to meet their needs. One staff said, "I had physical restraint training. I have refresher training but not all staff are trained as they are new". Staff received training in: Safeguarding of adults, physical intervention; which is used when peoples behaviour may challenge others, control of substances hazardous to health, infection control, document and record keeping, medication awareness, food safety, mental health, Mental Capacity and Deprivation of Liberty Safeguards, fire awareness, and health and safety. The service employed 19 staff. Out of the nine staff training records viewed one staff member who worked wake nights had not completed epilepsy training and five staff had not completed their fire awareness training.

One staff member had been observed through the communal surveillance whilst they worked alone. Observations had been logged in their staff file which detailed concerns around good practice and acceptable levels of care. The acting manager told us they had spoken to the staff member regarding their conduct but had not recorded this which they would usually do on a contact sheet. There were no further follow ups made to monitor if the staff had improved their practice, this left people at risk of receiving poor care.

Newly appointed staff were required to complete an induction to prepare them for working with people. A senior told us, "I normally do new staff induction. It's a long day, we go through fire; I show new staff where to complain. We cover health and safety and loads of other stuff. After day one new staff will come in to shadow other staff". New staff would be issued with a workbook which broke down areas to be covered in the induction over specific timeframes. Not all staff had fully completed their induction workbook before working without supervision. One staff member's induction book had been partially completed but this had not been signed off by a senior staff member, to ensure they had the required knowledge.

The failure to ensure staff received sufficient training and competency checks is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received supervision and appraisal which gave them the opportunity to discuss areas of their practice they wished to develop. A staff said they had recently had a supervision and could discuss any issues with the acting manager. They were confident they would be listened to if they had to ask for help or further support in between their supervisions.

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 is 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. The acting manager was in the process of making applications for people who needed to be deprived of their liberty and three DoLS authorisations had been granted. Prior to them taking up post, applications had not been made. The service had not notified the Commission when authorisations had been granted.

The provider had failed to notify the Commission of standard authorisations granted by the supervisory body. This is a breach of regulation 18 of the Health & Social Care Act 2008 (Registration) Regulations 2009.

Some people could display behaviours which were physically and verbally challenging. People had behavioural guidelines in their care plans to help manage incidents. Some people required physical intervention to re-direct their behaviour, prevent them from harming themselves and others around them. The acting manager told us, "I work closely with the safeguarding lead at the local authority. There had been an incident with two staff where restraint was used inappropriately. Now, no hands on used unless person is hurting others, themselves or destroying property". The acting manager reviewed all incident reports and asked staff for further detail where necessary before signing them off. All incidents reports were sent directly to the safeguarding lead at the local authority for review. This had been agreed following the incident where staff had used restraint inappropriately. The acting manager had implemented new incident recording sheets which had improved the way incidents were being recorded, monitored and analysed.

A healthcare professional said, "I have found that service users at The Hall have a good range of food on offer. As a lot of them are young, there seems to be an on-going battle with the service users wanting an unhealthy diet such as fizzy drinks, chocolates etc. The Hall tries to balance this". People had choice around their meals and menu choices were explained to them. During the inspection one person chose sausages instead of shepherd's pie. Staff spoke about food choices for the next day, and one person found this comforting to know what to expect and have their questions answered consistently around what would be on offer tomorrow. When people had specialised diets for example lactose intolerance this was catered for. Staff encouraged people to make healthy food choices.

A healthcare professional commented, "I think all issues to do with people's health and welfare are managed well". People were supported to receive appropriate treatment from outside professionals including dentists, psychiatrists and the opticians. A visitor said, "Managers have been professions and easy to work with. (Acting manager) has been really good and fights for the clients. One person needed help from other professionals and (acting manager) fought their corner". A person had suffered a mental health crisis and had been supported throughout this period to access the professional help they required. The service had adapted to help the person manage some behaviour which were challenging and complex. The persons relatives said, "I'm very happy with the care (person) receives. I think they (the service) are very aware of (persons) needs. They just seem to 'get' (person). An independent psychiatrist provided support to people, and visited during the inspection. Their remit was to provide independent support confidentially to people and provide specialist training to staff.

Requires Improvement

Is the service caring?

Our findings

A community living agreement stated: Smoking: service users are requested to have their last cigarette at 11pm, sweet and drinks in bedrooms, this is acceptable in small quantities, all service users must however keep their rooms clean to prevent infestations. Evening treats must be eaten at the table, not in the lounge. You may access the summer house Monday-Sunday until 10pm and Friday and Saturday until 11pm. The tone and language staff sometimes used with people was uncaring. An example of this was when a staff member said to a person, "Don't lie, that's not what happened, yes, we already discussed that. It's not always about activities you know, that's not real life, nobody does activities every day, you have to do your jobs too". We raised this as a concern with the acting manager This is an area that requires improvement.

A healthcare professional said, "I have to say that I have been very impressed with the level of dedication and care provided by this service to my client. My client has very complex needs and in the last 12 months suffered a mental health crisis. The service could have easily served notice due to difficulties with (persons) psychotic illness but helped maintain them in the community and have advocated there needs to get them the necessary services required". Another health care professional commented, "I found staff to be honest, kind, and caring in their approach to service users". We observed other interactions during the inspection. Staff spoke to people in a friendly way. One staff offered a person a cup of tea and another staff offered and gave a person a piece of fruit. Staff used a playful nickname with one person who enjoyed this and asked lots of questions which the staff answered. Staff engaged with the person in a jolly, friendly way. One person came to the team leader's office to ask for more coffee which staff helped them with straight away.

Staff were genuinely concerned about people's welfare. A person had left the service and moved out of the area to another placement which subsequently had broken down. The service had supported the person to move back and resume their placement with them. The person's relative commented, "It's very good I'm really happy. (Person) has really changed for the better. It's all excellent; I think they've done well with (person). I'm happy with (person) and proud of the progress (person) has made".

Staff understood people's individual needs well and were mindful of their likes and preferences, one staff commented, "We have to be careful where we take (person) if it's busy, we would take (person) to a quiet area like the woods. It depends on (persons) frame of mind, we play it by ear". People's bedrooms were decorated in a meaningful and personalised way. Staff respected people's privacy and asked for permission before entering peoples personal space.

During the inspection people often sat in the courtyard with each other and staff and chatted in a sociable, relaxed way. One person was sitting in the lounge with staff watching their favourite programme on television; staff were conversing with this person in a friendly and respectful way. One staff commented, "What I love about this service is that we are friendly with people and banter with people". People were supported to use advocates when they needed help with particular decisions or lacked the capacity to make independent choices.

Requires Improvement

Is the service responsive?

Our findings

There was inconsistency in care planning. Some documentation gave good descriptions of how people should be supported and were clear in instruction of how staff should respond to people in particular situations. However, other care plans lacked detail and were not person centred. It was important for one person to speak to a relative every week, if this did not happen it could be a trigger to their behaviour. This information had not been documented in their care plan which meant staff who may be unaware of this could miss triggers to behaviour which could have been prevented. Staff said it was important that people unknown to a person did not walk by their bedroom unaccompanied by staff as this could increase the person's anxieties. This important information was not recorded in their care plan which meant the person would be reliant on staff who knew them well to support them in a way they needed. A person had been prescribed a medicine as PRN. Their care plan made no mention of this, and information had not been noted on the behaviour plan or the medicine list to inform staff. This left the person at risk of receiving this medicine inconsistently. A need for more appropriate activities was highlighted in a person's plan but there was no evidence of alternative activities being provided or how this would be achieved which meant the persons identified needs were not being worked towards or met.

Behaviour Management Plans were in place to inform staff of the behaviours people could display. One person's guidance included reactive rather than preventative support measures and lacked detail to describe how staff could minimise behaviours before they would escalate. Their behaviour plan stated: 'Staff will support (person) to try to overcome the need to be verbally abusive towards staff when they are upset'. This did not give a detailed description of how staff should achieve this. There was clear, descriptive guidance in how to implement physical intervention techniques to prevent further injury to the person or other people should their behaviour become physical.

Care plans and guidance lacked sufficient detail to ensure people were receiving person centred care and treatment appropriate to meet their needs and reflect their personal preferences. This is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plan documents showed that people had been encouraged to be involved in writing their care plan and had the opportunity to say what was important to them. Documents contained information from managers, staff, and the person themselves. Sections of the plan included, general description, relatives, health, disability, communication, activities and employment, leisure, finance and views on living at the service.

When people moved between the service this was completed in a thoughtful and person centred way. Positive steps were taken to ensure people were placed appropriately. For example, one person was working towards moving on to a smaller service to better suit their needs. A staff member told us, "We've refused to provide services to people we can't meet needs for. I think (provider) does want to help people". There was a referral questionnaire used for perspective people moving into the service. It contained detailed information about people involved in the process and described behavioural triggers and interventions that staff should consider when providing support. The questionnaire contained detailed information of life skills

and stated what level of independence the person had. This helped determine if the service would be able to meet a person's personal needs. A healthcare professional said, "The service user who I placed there is challenging. They (the service) have worked well to establish boundaries, and have worked well with (person) and their family. Although from time to time there are issues with (person), (person) is doing well and 100% better. The staff at The Hall are like family to (person) and (person) has spoken to me about this".

People were supported to participate in activities within the service and outside and were helped to find work opportunities if they wished. During the inspection some people went clothes shopping, to have lunch out or to The Hub. The Hub is a day service the provider had set up in the local area for people to use. There were various activities people could choose from at The Hub such as cooking, being supported to apply for jobs and learn other life skills. Four vehicles were available for people to use to access activities outside of the service. People also had access to various game consoles in the service and used the outbuilding for playing games and relaxing. During the inspection one person was using the out building to play games. They said, "I'm playing the games console. I can go out alone but don't want to today".

One person said, "I can tell staff if I'm not happy". A relative commented, "I can tell them if I have any concerns". A complaints policy was available and displayed in the entrance of the service. The policy gave timescales and details of who people could seek further help from should they be unhappy with the response they received from the service. One of the senior managers said, "People are aware how to complain, it's usual for them to make general complaints about each other, like I don't think it's fair so and so doing this. They can discuss this in their one to ones". When complaints had been made these had been responded to and records kept in the complaints folder, there were no complaints at the time of the inspection.

Requires Improvement

Is the service well-led?

Our findings

The culture of the service was not wholly person centred. People were not always treated in a way which promoted their freedom and choice. The acting manager was working towards improving this which they recognised would be a challenge as changing a culture of a service can be a long process. They said, "I've worked really hard to make changes over the last year. It's hard with the staff as they've worked like this for a while. Some of the old terminology used is still used now. I need to change this. Lots of things have been in place here for a long time, it's been the norm".

People were not protected by effective checks and audits. External monthly quality monitoring assurance was being conducted which gave details of how the service needed to improve. There were no recorded follow ups or outcomes to demonstrate if improvements had been made; no action timescales had been implemented. For example on the 5 August 2015 a log stated a person was unhappy at the moment as they felt the other people were teasing them. There was no follow up recorded to show how this had been resolved. Another entry on the 18 September 2015 stated a person was happy living there but would like to change bedrooms. Again there was no action plan or outcome to show how this had been responded to. This inspection highlighted shortfalls in the service that had not been identified or addressed by the monitoring systems in place. Examples of this were the use of a person's PRN medicine, risk management and monitoring of the suitability of staff. The provider had not put measures in place to reduce the risk of staff who had been identified as needing to improve their practice when supporting people. Some safety checks were missing and this had not been picked up in the provider's internal audits which put people at risk. For example monthly emergency light and drills, weekly fire alarm checks, and monthly medicine checks.

The systems for assessing and monitoring the quality and safety of the service provided was not always effective. This is a breach of regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

A healthcare professional said, "I think the management team at The Hall work well with service users changing needs to help them have a better quality of life and future". Some auditing had been successful in making improvements to the service. A senior manager had completed a compliance check in March 2016 and had picked up the lack of fridge/freezer temperature recordings, which had now improved meaning people, were being protected by safe practice. A healthcare professional said, "The manager and the provider both seem very committed and were happy to take on suggestions and have responded promptly".

Improvement had been made since the acting manager had taken up post. The acting manager told us, "The staff have a good rapport with me now, it's been difficult. I've done my best fighting for people's rights". Staff meetings were arranged to discuss improvements to be made and what was going well. Highlighted in a meeting in March 2016 was the need to update how incidents were being recorded. This had now been improved by the acting manager. Also highlighted in the meeting was seniors becoming more active in helping resolve problems with paper work, and risk assessments being updated. The acting manager had

made a plan to improve how senior staff would be deployed so the service would run more smoothly. There was a list of dates arranged for future staff meetings visible in the office. This demonstrated staff were being given the opportunity to have regular formal contact with the management to discuss how the service could improve.

There was a good system to organise the day and ensure individual needs were met and tasks were completed. A handover sheet was used for each shift which designated specific responsibilities and tasks to staff. This included who would be running the shift, which person staff had been allocated to work with, and any appointments or events staff needed to be aware of. Staff that were allocated to run the shift would be in charge of medicines, money, areas of cleanliness, and allocation of staff hours. This avoided confusion and made staff accountable.

Logs were made in conversation books of feedback people had been asked to give about the service they were receiving. This demonstrated people were actively involved in making the service a better place to live. The relatives we spoke to said they felt able to raise any concerns with the provider which would be listened to. A healthcare professional said, "The service have continued to liaise with us, keep us updated and have developed a good working relationship with my client's family. (The acting manager) has been a huge asset to the management team since they took on this role".

Senior management recognised that areas were in need of improvement to deliver better outcomes for the people living at the service. A senior manager said, "The inspection has shown me areas we need to improve and more support is needed for the acting manager". The service had received several compliments including: 'Feels homely, has a friendly atmosphere and everyone welcoming', and 'Big thank you for all your support. I was extremely impressed with the commitment of staff/management who looked to ensure the best outcomes for their young people'.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of standard authorisations granted by the supervisory body. Regulation 18(4A)(a)(4B)(c)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans and guidance lacked sufficient detail to ensure people were receiving person centred care and treatment appropriate to meet their needs and reflect their personal preferences. Regulation 9(3)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonable practicable to mitigate risks. The provider had not ensured the premises was safe for people to use, had not provided appropriate equipment to mitigate the risk of harm to people and safety checks were inconsistently completed. The provider had failed to have proper and safe management of medicines Regulation 12 (1)(2)(a)(b)(d)(e)(g).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems for assessing and monitoring the quality and safety of the service provided was not always effective. Regulation 17(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a lack of effective and safe recruitment processes Regulation 19.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to fully meet people's needs. Regulation 18(1)(2)(a).