Peninsula Autism Services & Support Limited

Coolhaze

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
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 14 and 15 March 2017 and was unannounced.

Coolhaze provides care and accommodation for up to three people. At the time of the inspection two people were living at the home. Coolhaze provides care for people with a learning disability and associated conditions such as autism.

The inspection was prompted in part by notification of an incident involving a person using the service. Other organisations are looking at this incident. During this inspection we looked at risks and if people were safe.

The service had a registered manager in post. 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. At the time of the inspection the registered manager also had responsibility for another home, which was located within close proximity of Coolhaze. A deputy manager was also in post at Coolhaze to assist with management tasks.

The inspection in 2015 raised concerns about inconsistencies in management. At this inspection we found the inconsistency in management had still not improved. At this inspection there was a registered manager who had been in post for seven months, however, they were soon to leave. Prior to the current manager and since our last inspection there had been two different acting managers overseeing the service.

Staff said these frequent changes in management had been confusing and unsettling. Comments included, "We just get to know one manager and how they work then they leave, it must affect the people living here and the quality of care". Staff said admissions of new people needed to be overseen by a consistent and skilled management team, "People have been admitted by one manager and then they leave, a new manager has to pick up where one left off". Staff said they did not feel this was a safe way of admitting people who could have very complex care needs.

Although the regional manager who had only been in post a month prior to the inspection said they had recognised that Coolhaze required consistent, skilled management this had not been recognised and appropriately addressed by the provider as part of their quality monitoring of the service.

The service was not always responsive to people's individual and specific needs. Some parts of the environment did not meet people's needs and did not promote their privacy and independence. One person used a wheelchair in the home, however, the environment had not been adapted sufficiently to promote the development of skills and independence. The layout of the person's flat meant they could not always undertake personal care tasks independently or in private.

We saw risk assessments and risk management plans were in place. These assessments included detail of any potential or predictable risks and how these should be managed and minimised. Risk assessments related to the environment and people's particular needs and lifestyle choices. We saw following a serious incident risk assessment and management plans had been reviewed and updated to help ensure people were safe. These reviews and changes had been agreed in liaison with other relevant agencies, including the specialist learning disability team.

People living at Coolhaze had complex care needs and required a high level of support with daily care needs inside and outside the home. Staffing levels had been agreed with the funding local authority and documented as part of a person's plan of care. We saw staffing levels and how people were supported was discussed and reviewed regularly. Staffing levels had been increased when required to ensure they remained appropriate and safe.

The provider had clear and effective recruitment procedures in place and carried out checks of all staff working in the home to ensure they were appropriate to work with vulnerable people. People were protected by staff who knew how to recognise and report possible signs of abuse. Staff said reported signs of abuse or poor practice would be taken seriously by the registered manager and provider.

People had their medicines managed safely, and received their medicines in a way they chose and preferred. People were supported to maintain good health and when required had access to a range of healthcare services.

All staff, including those employed by an agency undertook a thorough induction when they first started work in the home. Training was on-going and relevant to the service and needs of people being supported. Staff said they felt the training was appropriate to their role and said they felt well supported by management and their colleagues.

Staff spoke positively and with compassion about the people they supported. We spoke with an agency member of staff who was working with one person on a temporary basis. They were able to tell us in detail about the person being supported and focused on the positive aspects of the person's life such as their lively personality, interests and hobbies.

Management and staff understood their role with regards to the Mental Capacity Act (2005) and the associated Deprivation of Liberty Safeguards. Applications had been made and advice sought when necessary. When people were unable to consent to their care or support, or were unable to make decisions, discussions took place with relatives, other agencies and staff in the home to help ensure decisions were made in their best interest.

Where possible people were supported to make choices about their daily routines and lifestyle. We saw people making choices about what they wanted to wear, what they wanted to eat and how they wanted to spend their day. People had the opportunity to partake in activities they enjoyed and to maintain relationships that mattered to them.

The registered manager undertook regular checks of the environment as well as completing a range of quality audits, covering medicines management, staff training and health and safety.

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the 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?

Good

The service was safe.

Systems were in place to assess and manage potential and predictable risks. Assessments and guidelines were reviewed and updated when required to ensure they remained appropriate and safe.

People were supported by sufficient numbers of skilled staff to keep them safe. Staffing levels were reviewed regularly and adjusted when required.

People were protected by staff who could identify abuse and who would act to protect people.

People were protected by safe and appropriate systems for handling and administering medicines.

People were protected by safe and robust recruitment practices.

Is the service effective?

Good

Most aspects of the service were effective. However, we recommend some improvements are made.

The design and layout of the home did not in all cases meet people's needs and promote their independence.

People were supported by staff who new them well and who received appropriate support and training to meet their needs.

People were assessed in line with the Mental Capacity Act 2005 as required. Staff asked for people's consent before providing care and respected their response.

People's behaviours were understood and systems were in place to help ensure they were managed safely and appropriately.

People were supported to have their health and dietary needs met.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Some aspects of the environment did not promote people's privacy, dignity and independence.

People were looked after by staff who treated them with kindness and respect.

Staff spoke about the people they were looking after positively and with fondness.

People were supported to maintain relationships with people who mattered to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support, which reflected their specific needs.

People's supported arrangements were reviewed and updated on a regular basis. Other agencies and relatives were involved in this process when possible.

People were supported to lead a full and active lifestyle.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The management of the home was not consistent and did not always ensure people's needs and safety were overseen and monitored appropriately.

Quality audits were not always effective in ensuring the quality of the service.
The outcome of complaints were not always used effectively to improve to learn and improve the quality of the service.

People were supported by staff who had the opportunity to reflect on their practice and discuss their role within the service.

Coolhaze

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 checked 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.

The inspection was prompted in part by notification of an incident involving a person using the service. Other organisations are looking at this incident. During this inspection we looked at risks and if people were safe.

This inspection took place on the 14 and 15 March 2017 and was unannounced. The inspection was undertaken by one adult social care Inspector.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events, which the service is required to send us by law.

People who lived at Coolhaze had some communication difficulties due to their learning disability and associated conditions, such as autism. People were not able to tell us verbally about their experience of living at Coolhaze. We spent short periods of time with people seeing how they spent their day and observing the interactions between people and the staff supporting them. These observations helped us understand if people were happy with the care being provided.

In addition to our observations, during the inspection we also spoke with 8 members of the staff team. This included the registered manager, deputy manager and care staff. At the end of the inspection we spoke with the regional manager for the organisation and provided headline feedback of our findings.

We looked at the care records of both people living in the service, and this included support plans, health records and daily monitoring forms. We also looked at a range of other records relating to the running of the

service including, policies and procedures, staff files, training records and quality audits.

Following the inspection we spoke with two professionals from the local community learning disability team.

Good

Is the service safe?

Our findings

The inspection was prompted in part by notification of an incident involving a person using the service. Other organisations are looking at this incident. During this inspection we looked at risks and if people were safe.

We saw risk assessments and risk management plans were in place. These assessments included detail of any potential or predictable risks and how these should be managed and minimised. Risk assessments related to the environment and people's particular needs and lifestyle choices. For example, one person had been assessed by specialist services as being at high risk of choking. We saw guidelines were in place to minimise these risks, which included the required staffing levels, and dietary requirements for this person. We saw staff following these guidelines when supporting this person to eat and drink.

Prior to the inspection the provider had told us an incident had occurred, which had resulted in harm. The circumstances of this are being investigated and the results of that investigation will be shared with us.

We looked to see if the risk of harm could have been predicted and prevented. We found risk assessments and management plans were in place relating to identified risks. These had been kept under review. Since the incident, risk assessments and management plans had been further reviewed and the registered manager had worked alongside other relevant agencies to help ensure the person and others were safe. Other agencies, including the specialist learning disability services said the registered manager had liaised appropriately with them to ensure the person's support arrangements were safe and in the person's best interests. The acting regional manager had been visiting the service weekly to support the registered manager and had also liaised with the local authority and specialist learning disability team to consider the longer term care needs and management plans for the person concerned.

People living at Coolhaze had complex care needs and required a high level of support with daily care needs inside and outside the home. Staffing levels had been agreed with the funding local authority and documented as part of a person's plan of care. We saw staffing levels and how people were supported was discussed and reviewed regularly. Staffing levels had been increased when required to ensure they remained appropriate and safe. Staff said they felt staffing levels were safe and said they felt safe when providing support to people. Comments included, "The agreed staffing levels are always in place, we are never put in a position of feeling unsafe".

Staff knew people well and had undertaken specific and relevant training to meet people's needs appropriately. For example, one person had very specific needs in relation to their health and diet and staff had undertaken training and worked alongside healthcare professionals to better understand the person's needs and how they should be supported. When the provider had assessed staff may not have the skills or confidence to support people they had ensured appropriate staff were recruited and in place to safely meet people's needs.

All staff said they felt well supported by their colleagues and management team. They said they had

opportunities to discuss practice and to raise concerns at any time. Comments included, "If we are unsure of anything we just ask, there is always someone available to support us or to talk about any issues we may have".

People were protected by staff who knew how to recognise signs of possible abuse. Staff said reported signs of abuse would be taken seriously and investigated thoroughly. Staff had completed training in safeguarding adults and this was regularly discussed and updated. The training helped ensure staff were up to date with any changes in legislation and good practice guidelines. Detailed policies and procedures were in place in relation to abuse and whistleblowing. Staff knew who to contact externally if they thought concerns had not been dealt with appropriately within the service. Agency staff working in the home had access to all safeguarding policies and procedures and were expected to familiarise themselves and understand this information as part of their induction.

Assessments had been completed in relation to risks associated with the environment. People had personal evacuation plans in place, which helped ensure their individual needs were known to staff and other services in the event of a fire. A fire risk assessment was in place, and regular checks completed of fire safety equipment. Environmental audits and maintenance plans helped ensure the environment was safe and fit for purpose.

People were protected by safe and thorough recruitment practices. Records confirmed all employees underwent the necessary checks prior to commencing employment to confirm they were suitable to work with vulnerable people. The registered manager ensured all required checks had been completed for agency staff working in the home, and contacted the agency if they had any concerns in relation to staff recruitment or practice. An agency file was held in the service with a profile of each agency staff member. This included information about recruitment checks, training, experience and induction to working at Coolhaze.

Medicines were managed, stored, given to people as prescribed and disposed of safely. People's care records had detailed information regarding their medicines and how they needed and preferred them to be administered. Any allergies were known and highlighted at the front of the person's file. Protocols were in place for people who needed as required (PRN) medicines, and these guidelines were known and understood by staff. Staff undertook training and understood the importance of the safe administration of medicines. Staff said they undertook regular competency checks to test their knowledge and to help ensure their skills were up to date and in line with best practice.

Good

Is the service effective?

Our findings

People had their own separate living accommodation within Coolhaze. A communal kitchen was also available, which people could use with the support of staff. We spent time with one person in their flat situated on the ground floor of the property. It was noted that some aspects of the environment did not meet the person's needs in relation to their mobility. For example, although the person was able to partake in cooking tasks and staff said they enjoyed baking, these activities were limited as the person required the use of a wheelchair in the home. Although they could get into the kitchen the design meant they could not reach the worktops in their wheelchair. The staff said they supported the person by placing a small table over their lap when they were baking but recognised an environment with appropriate adaptations could further enhance their independence. The person's flat also had poor natural light, which was made worse by the curtains frequently needing to be drawn due to the flat being positioned by the entrance to the service.

We recommend that the service seeks advice from a reputable source in relation to equipment and environment to meet the needs of people with a physical disability and mobility needs.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions attached to authorisations to deprive a person of their liberty were being met. The 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 as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive.

Management and staff demonstrated a good understanding of the Mental Capacity Act (2005) and had undertaken appropriate training. Support plans included information about people's capacity in relation to different areas of their care and lifestyle. Plans highlighted when people were able to make decisions for themselves or when best interest decisions would be needed to support them.

People living at Coolhaze at the time of the inspection had been assessed as requiring constant supervision and were unable to go out of the home without staff support. The registered manager was aware of the need to consider people's ability to consent to these supervision arrangements within the legal framework of the Mental Capacity Act 2005 (MCA). People can be deprived of their liberty in order to receive care and treatment, which is in their best interests and legally authorised under the MCA. The authorisation for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of this process and had made applications under DoLS when they were required. Any authorised DoLS applications had been kept under review to ensure they remained appropriate for the person concerned. Staff understood the authorisations that had been approved and were following them in practice.

Some concerns were expressed by other agencies that due to the environment the support arrangements for some people could be overly restrictive. For example, one person had been assessed as needing three staff to support them at all times. Due to the layout of the home the three staff had to be situated within the person's flat and personal space at all times. We were told this arrangement was temporary, whilst

alternative arrangements for the person were being agreed. The regional manager said they had spoken with the funding authority for the person concerned and had agreed a timescale for alternative arrangements to be made. Staffing levels and the way the person was supported had been kept under regular review by the service and other agencies to ensure they remained appropriate and safe. Records confirmed any restrictions had been legally authorised under a Deprivation of Liberty Safeguards Authorisation and by independent assessors as part of this process in line with the Mental Capacity Act (2005).

Staff were aware of people's rights and supported people where possible to move freely and safely around their home. People living at Coolhaze had their own separate accommodation with their own facilities including, bathroom, lounge and enclosed garden. This meant people could maintain a certain level of independence and freedom even when they required close supervision by staff. For example, one person had a lock on the main front door due to risks, however, the door to their garden was unlocked at all times and they were free to use this area whenever they chose to do so.

We spoke to the management and staff about people's rights and capacity in relation to different areas of their lifestyle. All of the staff said they encouraged people to make their own choices and decisions whenever possible. We saw people being supported to make daily choices about what they wanted to eat and drink what they wanted to wear and activities they wanted to do during the day. One person liked to shower a number of times throughout the day. They had their own bathroom facility and staff supported the person to make these choices and shower as often as they wanted.

Staff confirmed they undertook a thorough induction when they started work in the service. Comments included, "I have never had such a good induction, other places I have worked have not prepared me so well". Agency staff said in addition to the training provided by their employer, they also completed an induction programme when they started work at Coolhaze. We saw a copy of the agency induction plan, which included an introduction to the organisation and specific information about the people they would be supporting.

Staff said they had opportunities for training relevant to their role and people they supported. Each staff member had a training profile and training consisted of a mix of computerised and face-to-face learning. Some of the training was generic to the service and all staff were required to complete such as health and safety, food hygiene and fire training. Other training was more specific and linked to the needs of people the service supported, for example diabetic care and epilepsy training. A specialist trainer was also available within the organisation to support staff in relation to the management and understanding of people's behaviour.

Staff told us they felt well supported by management and their colleagues. Agency staff who were working in the home on a temporary basis received support from the registered manager as well as the specialist community learning disability team in relation to the specific person they supported. An agency staff member said, "We feel part of the team, the manager or deputy manager is always available if we need any support or have any concerns". Some of the staff who had worked in the home in the last two years said due to frequent changes in management the quality of support could at times be inconsistent.

Staff were supported to understand and manage people's behaviours safely. Behaviour management plans were in place for people to help staff understand the behaviour people may present, to recognise the triggers and signs and to manage the behaviours safely and appropriately if they occurred.

Following a recent incident when a person's behaviour had escalated beyond what was known and

previously experienced by the service behaviour management plans had been reviewed and updated. These changes had been agreed in liaison with the community learning disability team and behavioural advisors who were working closely with the staff to provide guidance and support. An agency team of staff with particular skills in supporting people with complex needs were supporting the person, whilst long term care arrangements were agreed. The agency staff demonstrated a good understanding of the person's behaviours and said the positive behaviour management plan focussed on understanding the triggers and using their knowledge of the person to diffuse situations and prevent behaviour from escalating. Agreements were in place between the home and other agencies to closely monitor the person's behaviour and to identify any patterns. The registered manager said this monitoring was intended to ensure the person's needs were being met appropriately and to also assist with the planning of their long term care arrangements.

We were told if people's behaviour escalated to a point where the person or others were considered at risk of harm the use of physical restraint or medicines could be required. We saw arrangements were in place to make sure the decisions about the use of restraint were made appropriately and recorded. Behaviour management plans detailed physical restraint as a last resort when all other options had been considered. The plan described what type of restraint could be used and the training requirements of staff to ensure the person's safety and well-being at all times. Protocols were in place in relation to the use of medicines to manage people's behaviour. These protocols helped ensure decisions about the use of PRN medicines were made appropriately and recorded.

People were involved when possible in decisions about their meals and mealtimes. Each person had their own kitchen area and were able to have snacks and drinks when they wanted. People went out with staff to shop and were encouraged when possible to get involved in planning and preparing meals. One person particularly enjoyed baking cakes and biscuits and staff supported this as a regular activity.

When people had known health needs or risks associated with their diet, plans were in place to support them and keep them safe. One person had dietary needs associated with diabetes and had also been assessed as a high risk of choking. Plans were in place to minimise these risks whilst also supporting the person to enjoy food, drinks and snacks of their choice. Staff had observed one person's behaviour became more difficult if they missed meals so had encouraged regular mealtimes as well as supporting the person to have access to snacks throughout the day.

People's health needs were met. People were supported to maintain good health and when required had access to a range of healthcare services. Annual health checks were arranged and 'hospital passports' were in place to support any admissions to hospital. Hospital passports contained important information about the person to help ensure their needs were met if they should require an admission to hospital or other healthcare facility. People's health needs were monitored closely and any concerns or changes were dealt with promptly. For example, one person with limited mobility had recently developed a pressure sore. Advice had been sought from health professionals and plans were in place for the person to have regular checks by the local district nurse team. Pressure relieving equipment was also in place to prevent any further deterioration in the person's skin.

Requires Improvement

Is the service caring?

Our findings

Due to people's learning disability and limited communication they were unable to tell us verbally about their experiences at Coolhaze and if they felt well cared for. We spoke with staff and other agencies and when possible during the inspection observed people's care and how they occupied their day.

We saw people's privacy and dignity was promoted and respected by staff supporting them. We saw staff knocking on people's doors before entering. Staff said they promoted people's dignity by closing curtains and doors when providing personal care and allowing people space and privacy when they requested. However, we saw some aspects of the environment did not always promote people's privacy, dignity and independence. For example, one person's bathroom had to be accessed through their kitchen. Although the person liked to spend time in their bedroom and could use the bathroom independently they had to go through the kitchen where their support staff and other visitors could be sat. This did not promote their privacy and independence The position of this person's flat also meant they had to have the curtains drawn regularly throughout the day as their windows looked out onto the main driveway and access to the house. This meant the person's curtains often had to be drawn restricting natural light even if this was not what they wanted or needed.

People's privacy and independence was not in all cases respected and promoted. This is a breach of Reg 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other agencies said they felt staff had a good knowledge of the people they supported and were always approachable and keen to learn and follow advice. They said they felt this showed staff cared about people and the progress they made.

We saw a team of agency staff supporting one person who had been assessed as needing constant supervision to keep them and others safe. The person appeared very relaxed in the staff's company, and there was plenty of laughter and friendly conversation. The person had particular interests, which they liked to talk about and requested frequent feedback and responses from staff about these topics. We saw the staff were very familiar with the person's interests and used words and gestures, which the person enjoyed and responded positively to. A large shed was accessible to the person in their private garden area and this had been made into an area where they could pursue hobbies and activities they enjoyed.

Staff spoke positively and with compassion about the people they supported. We spoke with an agency member of staff who was working with one person on a temporary basis. They were able to tell us in detail about the person being supported and focussed on the positive aspects of the person's life such as their lively personality, interests and hobbies. They said, "Even though we know there are risks, it's important to get to know the person and focus on what is good, we can use what we know they enjoy to help them deal more appropriately with situations they find difficult".

Management and staff recognised the importance of family and friends in people lives. One person had a regular arrangement to visit a person who had previously lived in the home but had moved onto a different

service. The staff had recognised the value of this friendship and the importance of maintaining when the two people no longer lived together. The staff supported the person with the visits and said they were always enjoyed by all concerned. The registered manager said one person's family were not able to visit as often as they had due to their age and changes in health. They said they continued to support contact with the family by arranging regular phone calls and keeping them updated with any important events.

Agency staff talked with enthusiasm about the friendships the person they supported had made in the community. They said, "[….] loves to go to their favourite shop, they have people they know in the café and we go to see them every time we visit, it really makes them happy. The staff in the shop are great and make a real fuss of […] when they haven't seen them for a while".

Requires Improvement

Is the service responsive?

Our findings

People's support plans included information about their health and social care needs. Each area of the plan described the person's skills, preferences and the support needed by staff and other agencies. The plans were written in a personalised way and from the viewpoint of the individual concerned. All the staff we spoke with were able to tell us in detail about people's needs and daily routines. However, some care arrangements were not personalised or responsive to people's individual needs. For example, one person's living space did not have suitable adaptations to meet their specific needs in relation to their physical disability. This meant they were not able to fully develop and maintain their skills and independence. We looked at a complaint that had been sent by a relative, which stated that the service had not met the person's needs as planned. The provider had investigated the complaint and upheld a number of concerns stating that the service had failed to provide evidence that the person's care arrangements had been appropriately met.

The design and delivery of care was not in all cases person centred and did not demonstrate people's needs were met appropriately. This is a breach of Reg 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the admissions procedure for new people considering moving into the service. We saw an assessment of need was undertaken with visits arranged and information gathered from previous placements. We saw when people had moved into the home a transition plan had been agreed to make the move as smooth as possible. We asked about the admissions process for one person who was living in the home with complex needs. Although there were some records in the person's file about their admission, the registered manager had not been in post when they were admitted and was not familiar with the decisions that had been made at the time. The registered manager said they were aware that the admissions procedure for some people may not have always been as thorough as needed. They said it had been recognised that improvements were needed, and to address this Individual Support Designs had started to be developed. These plans would include information about the type of service a person ideally needed, including their daily routines, environment, and staff structure. They said this would support people as they moved between services and would help them to have the best package of support for future placements.

At the time of the inspection the service had one vacancy. The regional manager who had recently been appointed to oversee the service said they would not admit a new person until they were clear about the long term care arrangements of all people living in the service. They said there was a possibility people could move on from the service and this would need to be known before any new admissions were considered.

Care records were regularly reviewed and amendments made to people's support arrangements to reflect any changes. Each person had a designated keyworker, and keyworker meetings took place monthly to discuss aspects of the person's care, such as holidays, activities and their daily routines. The behaviour support advisor for the organisation also regularly reviewed people's support plans to further ensure the arrangements in place to support and manage people's needs in relation to their behaviour were

appropriate and understood by staff. At the time of the inspection this was also being supported by the community learning disability team who were monitoring and reviewing one person's support arrangements following a serious incident in the home.

All people living at Coolhaze needed support from staff to occupy and plan their day. Each person had a documented activities plan, which was used to help plan the rota and other requirements such as vehicles and other transport arrangements. Staff told us people were offered the opportunity to go out everyday. Some people had particular activities they enjoyed and these were planned alongside other unplanned and more spontaneous activities such as local walks, and trips out to the local shops.

One person's support plan said their day needed to be structured and boredom and inactivity could lead to an increase in behaviours that could challenge the staff and others. Staff were aware of this person's needs and described their daily routines, with opportunities to go out and partake in activities around the home. This person had very specific interests and engaging in activities they enjoyed was known to have a positive impact on their behaviour and well-being. A specialist assessment had also been undertaken by the speech and language services, which stated that the best way to engage the person was to talk about things they enjoyed. We saw staff spending time with the person talking about their favourite hobby and looking at items that particularly interested them. The staff were particularly skilled at using the person's preferred tone of voice and referring to particular words the person enjoyed. This response and understanding by staff clearly had a positive impact on the person's and they responded with laughter and smiles.

We were told one person enjoyed the sensory experience of lights and the sound from certain items such as extractor fans. This information had been documented as part of the person's support plan in relation to their sensory needs. A range of lighting the person particularly liked was available to them, and extractor fans had been fitted in their flat, which they could listen to and watch. Staff said these items were important to the person and had a calming and relaxing effect when they became agitated or distressed.

We looked at how complaints were managed by the service. A written complaints system was in place and we saw this included what action would be taken when complaints were received and the timescale. We looked at a complaint, which had been received by the service. We saw the complaints procedure had been followed and a full investigation into the concerns raised had been undertaken by the provider within the agreed timescale.

Requires Improvement

Is the service well-led?

Our findings

The management of the home had not been consistent over time and did not always ensure people's needs were overseen and managed appropriately.

At the time of the last inspection in 2015 an acting manager was overseeing the day- to- day running of the service. There had been a number of management changes and staff had previously raised concerns about this inconsistency and the potential impact this could have on people using the service. It was noted at the time of the inspection in 2015 that a core group of staff were working hard to maintain the quality of the service. At this inspection we were told the inconsistency and changes in management had continued and the service had been overseen by acting managers up until the present manager registered in August 2016.

The service had a registered manager who was present throughout the inspection. They were also registered to manage another service, which was located within close proximity of Coolhaze. Prior to this inspection the acting regional manager for the service had informed us that management changes were again due to take place and the registered manager for Coolhaze would be leaving and returning to oversee the daily running of the other service. On the day of the inspection interviews were taking place at the home to recruit a new manager for Coolhaze. The regional manager said they had recognised the need for Coolhaze to have a manager on-site at all times with the skills required to manage a service for people with complex needs.

Staff were very positive about the registered manager and said there had been significant improvements since they had been in post. Comments included, "The registered manager is really supportive, they are always available, even if they are not at the home we can contact them for advice and support", and "The manager has worked really hard to maintain a safe environment for people". However, staff said the constant changes of management was unsettling and confusing. One staff member said, "We just get to know a manager and then they leave, they all work differently, we don't always know what is happening, so it must affect people using the service".

Staff also felt the inconsistency in management could be unsafe and could result in people's needs not being met appropriately". One staff member said, "One manager will admit a new person and then leave, a new manager arrives and doesn't really know about the person who has moved in, this cannot be safe". Staff were open and honest, and told us some reasons they believed the service had so many different managers in post, comments included, " They are thrown in at the deep end, they don't always know what they are taking on so leave very quickly after starting in post". Other agencies also expressed concern about the management of the service. They said they felt confident that the current registered manager was organised and understood about the needs of people being supported. However, they said they did not trust this would always be the case and had found the service at times to be disorganised without the presence of the registered manager.

We found inconsistencies in management had resulted in poor communication when new people had been admitted to the service. Management and staff said information about people's needs and how decisions had been made about their placement often "got lost" or "misinterpreted", as different managers came and

went. We asked the current manager about the admission of one person who had most recently moved into the service. They said they had not been managing at the time so didn't really know how decisions about the placement had been made.

Although staff said they felt well supported by the current manager they said the frequent changes in management meant support and information was often inconsistent and confusing. Comments included, "All the managers have different ways of working, we get used to one and then they leave". Staff said the current registered manager had promoted a more open and inclusive culture, where their views and opinions were valued. However, they said due to the frequent changes in management the culture within the service would sometimes change.

Staff and management said they had raised their concerns about inconsistency in management on many occasions within team meetings and other provider forums. Although the regional manager who had only been in post a month prior to the inspection said they had recognised that Coolhaze required consistent, skilled management this had not been recognised and addressed by the provider as part of their quality monitoring of the service.

Effective governance was not in place to assess, monitor and improve the quality and safety of the services provided. This is a breach of Reg 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had not in all cases included the current manager in investigations or outcomes of complaints. This could mean that action taken to address the issues raised or improvements were not monitored by the person responsible for the day to day running of the service

The inspection was prompted in part by notification of an incident involving a person using the service. This incident was being looked at by other organisations, which meant during this inspection we did not examine the circumstances of the incident. We did see that following the incident the registered manager had worked closely with all significant agencies to help ensure the safety and well-being of people and staff in the home. Consideration had been given to lessons learned and a number of changes had been made to safeguard people and improve the quality of the service. The registered manager said following the recent serious incident the provider was also in the process of undertaking their own internal investigation to consider any action that maybe needed as a result of what had taken place.

Staff were encouraged and supported to reflect on their practice and be clear about their role and responsibilities. Staff meetings were held to provide an opportunity for open communication and daily handover meetings took place to help ensure people were up to date with issues concerning people's care and daily support arrangements.

Incidents were documented, and included a detailed account of what had taken place. The registered manager undertook a de-brief with staff following any serious incidents to help ensure they had the support required and to consider any practice issues. Following a serious incident in the home additional plans were in place to include specialist learning disability professionals as part of a de-brief within 24 hours of an incident occurring. The registered manager said this provided extra assurances that appropriate action had been taken and to help ensure any guidelines or practice could be promptly discussed and reviewed.

The service had an up to date whistleblowing policy, which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt able to raise concerns and felt confident the management would act on their concerns appropriately.

The provider and registered manager promoted the ethos of honesty, learning from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The Duty of Candour is a legal obligation to act in an open and honest way in relation to care and treatment.

Out of hours spot checks and monthly compliance audits were carried out by the registered manager. The acting regional manager had only been in post a few weeks prior to the inspection but was visiting the service weekly and was working closely with the registered manager to get to know the service and prioritise any action needed.

Regular audits of medicines, people's personal finances and records were completed by management and senior staff and any issues were discussed with staff as part of supervision and staff meetings.

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 design and delivery of care was not in all cases person centred and did not demonstrate people's needs were met appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and independence was not in all cases respected and promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not always protected by effective governance to help ensure the quality of the service was maintained.