Consensus Support Services Limited

Strawberry Fields

Inspection report

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West Sussex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 31May and 1 June 2016 and was unannounced.

Strawberry Fields provides care and accommodation for up to 10 people with a learning disability. There were 9 people living at the home when we inspected and they ranged in age from 23 to 51 years.

All bedrooms were single and each had an en-suite bathroom with a toilet. The home has two lounges and a separate dining room which people were observed using.

The previous inspection report made four requirements regarding the following:
•□People not receiving care and treatment which met their needs and preferences
•□A failure to follow the guidelines of the Mental Capacity Act 2005 where people did not have capacity to consent to their care
•□A lack of effective systems and processes for assessing, monitoring and improving the quality and safety of the service
•□Staff not receiving appropriate training, supervision and appraisal

This inspection was carried out to check on how the provider was making progress on meeting these requirements. The inspection was brought forward from the planned schedule date of inspection due to concerns raised with us by the local authority safeguarding team about the safety of people. The provider sent us an action plan of how these requirements would be met. At this inspection we found action had been taken to meet these requirements but that further work was needed in a number of areas.

The service did not have a registered manager, but there was a new manager who had applied to the Commission for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post since February 2016 and whilst she has introduced a number of changes and improvements to the service these were not yet embedded and further work and time was needed in a number of areas.

The environment was in need of improvement and was not always clean. Communal areas were austere and institutional. Bedrooms were not always clean and staff did not follow safe hygiene practices when managing someone's incontinence.

There had been a number of incidents related to the management of behaviours which may challenge which resulted in staff and people being assaulted by people using the service. Staff reported there had been a reduction in the number of the incidents but the service's own records did not support this. Whilst these were addressed and reviewed, the frequency of their occurrence was not reducing which gave cause

for concern.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse.

Risks to people were assessed and care plans devised on how to mitigate these, which included the management of people's behaviour. We saw there were numerous examples of staff taking appropriate action to divert people from behaviours which were challenging.

There had been a number of changes in the staff and management of the service which funding local authorities and the safeguarding team expressed concern about. Staffing levels were under review at the time of the inspection. The provider had assessed one person needed additional staff support and was in negotiation with the funding authority about this. For the remaining people sufficient staffing levels were provided.

People received their medicines safely.

Improvements have been made regarding the training and supervision of staff but this needed to be enhanced to ensure all staff had received the required training.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We found the provider and registered manager needed to update their knowledge as well as the service's procedures where people did not have capacity to consent to their care or treatment and where DoLS were applicable. Where people lacked capacity to consent best interests meetings were held in line with the MCA guidance but the staff and manager did not have a system for assessing the capacity of people.

People were supported to receive adequate food and nutrition although we noted where one person needed to have their fluid intake and output monitored that this was not always done.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff demonstrated a caring attitude to people who they treated with kindness and respect. People were able to exercise choice in how they spent their time.

Each person's needs were assessed and this included obtaining a background history of people. Care was individualised to reflect people's preferences. Relatives and health care professionals gave mixed views as to whether the service met people's needs or not. Two relatives said care needs were met but one said they weren't. Three health and social care professionals said people's care needs were met and three said they weren't.

The provision of activities for people had improved and the staff and manger was looking at ways of expanding this. For example, two people had been on holiday supported by staff and there were plans for other people to do the same.

The complaints procedure was provided to people and their relatives. People said they had opportunities to express their views or concerns, which were listened to and acted on. There was a record to show

complaints were looked into and any actions taken as a result of the complaint.

A number of audits and checks were used to check on the effectiveness, safety and quality of the service which the provider used to make any improvements. However there were aspects of the service which required improvement that had not been completely addressed and some action plans did not have clear timescales for completion.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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 always safe.

Whilst incidents involving the behaviour of people were looked into and care plans gave staff guidance on how to support people with these needs, we were concerned at the number of physical altercations occurring between people which did not ensure their safety.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

The provider had identified one person did not have sufficient staff support and were looking to increase this.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The environment was not always clean and well maintained. Communal areas were austere and institutional.

Staff were trained in the MCA and DoLS but the manager and staff were not aware of when they needed to assess the capacity of people who were unable to consent to their care and treatment.

Improvements were made in the training and supervision of staff but further action was needed to ensure all staff receive adequate training.

People were supported to have a balanced and nutritious diet.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment

arranged where needed.

Is the service caring?

Good

The service was caring.

Staff had good working relationships with people who they treated with kindness. Staff demonstrated they had a caring attitude.

Care was individualised and based on each person's preferences.

Is the service responsive?

Good

The service was responsive.

Improvements have been made to ensure people had more person-centred care which reflects both their needs and preferences.

The provision of activities has improved and each person had a daily activities programme.

The provider had an effective complaints procedure. Complaints were looked into and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Whilst we noted many improvements to the service such as in staff attitude, activities and responsiveness to care needs the provider was aware these needed to be embedded and enhanced to ensure the service was well-led.

Staff described a change of culture which was led by the management team and had resulted in improvements to the quality of life for people. There were a number of systems for checking and auditing the safety and quality of the service.

Strawberry Fields

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 was unannounced and took place on 31May and 1 June 2016 and was carried out by one inspector.

We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with five people who lived at the home but only one person was able to speak to us in detail about their experiences because of people's communication needs. We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We also spoke to the relatives of four people who lived at the service.

We spoke with the manager, the deputy manager, a behavioural practitioner for the provider, an operations manager for the provider and three care staff.

We looked at the care plans and associated records for eight people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for five staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke to a member of the local authority safeguarding team and to a nurse from the local health trust learning disability team. We also had contact with four social workers responsible for supervising the placement of four people at the service. These people gave permission for their views to be included in this

report. We also looked at documents sent to us from health and social care professionals such as minutes of safeguarding meetings and correspondence from NHS health care staff.

The service was last inspected on 5 and 7August 2015 when concerns were identified in the provision of staff training and supervision, providing responsive care to people, using the MCA when people did not have capacity to consent to care and in assessing and monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 5 and 7 August 2015, we identified systems were not in place to assess, monitor and mitigate risks to people's health, safety and welfare. This was in breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to risk assessments not being reviewed and updated. The provider sent us an action plan to say how this was being addressed. At this inspection we found improvements had been made and this part of Regulation 17 was now met, although the provider's system of monitoring for trends in behaviour was not fully implemented. There were assessments regarding the risks of choking, risks of malnutrition, risks when supporting people with personal care such as bathing and going out in the community. There were corresponding care plans regarding action staff should take to mitigate the risks and so people were safely supported to lead a fulfilling life. Neurological conditions were assessed using a risk assessment and there was clear guidance for staff to follow when people experienced any seizures. A health care professional said they worked well with the staff regarding the monitoring and treatment of epilepsy. Examples were given of requests by this health care professional for the completion of assessments and charts to monitor the frequency of seizures which were completed well by staff where this had previously not been the case. On-going monitoring of this condition helped to identify trends and ways to reduce the risk of injury.

Whilst care plans highlighted how people's behaviour which challenged others should be handled the number of incidents of aggression between people since the last inspection led us to judge that people were not always protected from abuse.

Relatives gave mixed views on whether the service provided safe care. One relative did not feel it was safe due to the number of incidents at the service whereas two other relatives considered the service was a safe place and said staff took action to provide a safe environment for people to live in. A member of the local authority safeguarding team and two social workers from funding authorities expressed the view that the service was not safe due to the number of incidents of behaviour and aggression between people. The member of the safeguarding team said this was due to the mix of people with specific high needs rather than any failings in how staff managed behaviour. One of the social workers stated that even though their client received a staff ratio of one to one this had not been effective as there were a high number of safeguarding incidents and they did not feel the person's needs were fully met. Three other health and social care professionals said they thought the service was safe.

People at the service displayed behaviours which sometimes challenged staff and others living at the service. Information about this was included in people's risk assessments. Care plans gave guidance for staff on how to respond to people when they showed signs of distress or behaviour which challenged others. These included information about triggers that people may be developing behaviours and how staff should intervene so people's behaviour calmed. Care records showed this was effective in calming people in a number of instances, but the frequency of incidents occurring between people was still occurring on a regular basis.

Various monitoring tools were in place to record when people exhibited behaviour which challenged others as well as to record how the staff and management team reviewed incidents to see what could be learnt to reduce the chance of it reoccurring. The staff team were supported by a behavioural practitioner who

reviewed the incidents of behaviour for each person and advised staff on how to safely handle these situations. This included the completion of a monthly behaviour monitoring form although we noted the use of this monitoring system was still being developed for each person. For example, the behaviour practitioner said where it was necessary for staff to physically intervene with a person's behaviour a post incident analysis should be completed but this was not being done in all cases, although there was a review of each incident.
The manager and staff said the numbers of incidents regarding people's behaviour fluctuated but was lessening. Relatives also said people's behaviour had improved but one relative was concerned about the effect of behaviour on their relative at the service. We looked in detail at the records of behaviour for two people which showed variations in the frequency of incidents where staff needed to use physical intervention, but this did not show incidents were decreasing in frequency. The provider supplied data for the period since the last inspection of incidents where physical interventions had been used and when staff had intervened because of people's behaviour. This showed monthly fluctuations in the total number of such incidents as well as variations between different people but did not show a downward trend overall. For some people there had been a reduction in incidents but for others there was no noticeable decline. We therefore remained concerned at the service's ability to manage the behaviour of some people and the effect this had on the well- being others. It was not clear the staff and management could meet everyone's needs. For example, one person was assaulted six times by the same person in the six months preceding the inspection although staff had intervened to stop this and there was no injury to the person.

Three social care professionals were concerned about the number of incidents of aggression between people especially when taking account of the relatively large numbers of staff on duty. Discussions with the provider and manager, and records of investigations into incidents showed staff did not deal with people's behaviour in a safe way in January 2016. One of these involved several staff carrying out a procedure where a 'placebo' medicine of a sweet or sweetener was given to a service user for behaviour and distress instead of the prescribed medicine. This came to light when the provider carried out an investigation on behalf of the safeguarding authority. Action was taken to address this by additional instruction to staff. On the day of this inspection the manager and deputy manager confirmed this practice had ceased.
The provider had not taken action to fully protected people from abuse. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People told us they felt safe at the service and two relatives considered the service was a safe place and said staff took action to provide a safe environment for people to live in. For example, one relative said the provision of two staff to one person helped keep them safe. Another relative said people were comfortable and felt safe around staff.
Care records included guidance for staff on how to safely support people when they required physical intervention. Staff were specifically trained to deal with people's behaviour in a way which minimised the need for any physical intervention. Care records included clear details about the need for any physical interventions and how staff should support people by using the least restrictive non-physical intervention. Staff confirmed they followed these procedures and had a good awareness of using non-physical interventions to support people when they displayed behaviour which challenged others. There was also guidance on how staff should protect themselves when dealing with people's behaviour to ensure their own safety.

We observed a meeting between the outgoing and incoming staff teams on a change of shifts. This included discussions of people's behaviour and how staff were positive about noticing improvements in people's behaviour such as being more sociable.

The service had safeguarding policies and procedures regarding the protection of people from harm. Staff were aware of their responsibilities to report any concerns of a safeguarding nature to their manager and

knew they could also make contact with the local authority safeguarding team. Staff confirmed they received training in safeguarding procedures and that this was part of the training considered mandatory to their role. The manager and staff made referrals to the local authority safeguarding team where there were concerns about the safety of people. For example, the manager described an incident raised with her regarding a concern about how a person was treated. This was looked into and referred on to the local authority safeguarding team. A member of the local authority safeguarding team confirmed referrals were made regarding the safety of people and that staff and management cooperated with any investigations. A comment was made by the member of the safeguarding team that safeguarding alerts were late in being notified. The manager acknowledged this and said referrals were now made in a timely way, which our records confirmed.

Staff gave mixed views about the current staffing levels. For example, one staff member said there were enough staff to look after people safely but another staff member said more staff were needed and said, "We're struggling. It's really hard. Cooking and cleaning as well."

The service had five staff vacancies and recruitment was ongoing to fill these posts. Three staff were transferred to the service from another home in order to supplement the staffing. Agency staff and overtime for existing staff was also used to cover any shortfalls in staffing. The manager monitored the use of agency and overtime staff which fluctuated from week to week. Two health and social care professionals expressed views about the current staffing levels. One was concerned at the lack of consistency in staffing; both were concerned that when the three staff transferred from another service returned to their permanent posts it may lead to another change and a possible reduction in the skills of the staff team. The provider stated these staff would only return to their permanent posts once there was settled staff team.

Staffing levels were based on the assessed needs of each individual person. The manager explained that discussions were ongoing with the relevant funding local authorities regarding staffing levels. For example, the staff and management assessed one person as needing additional staff on a one to one basis in order to safely support the person. The manager said where people had a one to one ratio or more with staff then this had positive outcomes for the person and other people. The provision of safe staffing levels which met people's needs was still not confirmed and was under review.

Two people were supported by two staff each from 7am to 9pm each day and three people had a one to one ratio with staff. A further two staff provided support for four people. The staff duty roster showed between nine and ten staff on the early shift and nine to eight staff on a late duty.

During our inspection we observed there were enough staff to meet people's needs. Some people were on outings with staff and where people had a one to one we observed this taking place. Where people were supported by two staff we saw this was provided but that staff also allowed people space to express themselves.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting and completed a written assessment. Recruitment checks ensured staff were safe to work with people.

We looked at how the service managed people's medicines. There were policies and procedures for the safe handling of medicines. Only those staff who were trained, assessed and observed as competent to handle and administer medicines did so. Medicines were supplied to the service in a monitored dosage system

which meant the medicines were easier to handle as they were organised in a pack for each time the person needed the medicine. Staff completed a record each time they administered medicines to people. Stocks of medicines showed people received their medicines as prescribed.

Where people received medicines on an 'as required' basis for mental health needs and symptoms such as agitation, there was guidance for staff to follow when this was needed. The provider's monthly monitoring report identified some of the guidance needed to be updated which had still not been completed.

Checks were made by suitably qualified persons of equipment such as the gas heating, electrical wiring, fire safety equipment and alarms and electrical appliances. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises. Temperature controls were in place to prevent any possible scalding from hot water, and the temperature of water was also checked each time someone was bathed. Water temperatures were also checked regarding the prevention of Legionella. Radiators had covers on them to prevent any possible burns to people.

Requires Improvement

Is the service effective?

Our findings

The environment of the service did not meet the needs of people. Each person had their own bedroom with an en suite facility. These were personalised with people's belongings and pictures. One person was supported by staff to repaint his room in his chosen colour scheme. One person had requested a key to his bedroom which he used for security.

The communal areas of the main lounge and dining room were stark and devoid of homely decor. The main lounge had a high ceiling and hard floors and was more like a gymnasium than a lounge. Staff said the room was originally intended to be a hydrotherapy pool. Furniture in the main lounge was basic and apart from a television screen high on the wall there were no pictures or decorations. The dining room was also bare with tables and chairs and nothing else. These areas were used by people and the sound echoed around the building which did not enhance any feeling of calm. The provider told us at the last inspection that they planned to lower the ceiling in the lounge to make it more homely. However, this had not taken place. The manager said there were plans to use fabric on the ceiling to make the lounge less austere and for a specialist artist to paint displays on the walls of the communal areas. Two curved walls had been installed in the lounge to break up the space so it did not look so stark. However the space remained unfavourable to the needs of people living there. It did not have a warm or homely atmosphere which could calm people's behaviour.

Paintwork on doors and door frames were damaged. A communal toilet had flaking paint on the walls and paint splattered on the flooring. This did not promote the dignity of people living there.

Some of the carpets were stained including in a bedroom. One person's room needed to be thoroughly cleaned on a daily basis due to their behaviour needs. On the first day of the inspection we noted this had not included the ceiling where we noted what appeared to be traces of faeces. This had not been cleaned by the following day. The room also had an offensive odour. We also noted staff did not wipe the vinyl seating in the main lounge when a person was incontinent.

One person's room had cushioning on the walls to protect them because of their behaviour. This was installed by staff by gluing camping mats to the wall. Specialist advice about this was not sought which would have helped determine what equipment was suitable to protect the person. Whilst this looked effective it was unclear why the staff had to do this themselves and why a more specialist product had not been used.

The provider had not ensured the premises and equipment were clean, suitable for their purpose and properly maintained. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were supported by helpful staff who understood their needs and preferences. Relatives said there was a variation in the skill levels of staff but that on the whole staff provided effective care. We had contact with six health and social care professionals about the standard of care and skill levels of staff. A

health care professional reported on improvements in how staff provided care and said the new staff who transferred from another service, as well as the new manager, acted as a role model for the existing staff. The manager said there had been a high turnover of staff since the last inspection and said the newly appointed staff had allowed her and other staff to change the culture of the staff team which was said to be in some ways inflexible and not adaptable to meeting people's changing needs.

At our inspection on 5 and 7 August 2015, we identified the provider had not ensured staff received appropriate training and professional development. This related to a lack of clarity in the staff team about the policies and procedures for supporting people with their behaviour. This was in breach of Regulation 18 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to say how this was being addressed. At this inspection we found improvements had been made but that the influx of new staff still meant not all staff had received all the training considered mandatory to their role. The manager explained this was due to the number of new staff starting and dates were agreed for this to be completed. Staff described how they supported people with behaviour and said any physical intervention was avoided as they used techniques to divert and distract people from their behaviour.

Staff said they had access to a range of training courses which were of a good standard and supported them to provide effective care. The manager said there was now a more strategic approach to ensure all staff received the appropriate training and supervision. Newly appointed staff enrolled on the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standard that should be covered as part of induction training of new care workers. A member of staff who recently started work at the service described how their induction consisted of working with more experienced staff in a 'shadowing' role to observe how they looked after people. Staff confirmed their induction included training in areas considered mandatory to their role followed by an assessment of their ability to work unsupervised. Where staff were promoted within the service a new induction was completed to prepare them for their new role.

Staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. Fifteen of the 35 staff were trained at NVQ level 2 or 3. Two further staff were studying level 2 and the manager had level 4 plus a management qualification called the Registered Manager's Award (RMA). These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Staff told us the frequency of their supervision had improved and the manager confirmed each staff member was due to have an appraisal. Records were maintained of staff supervision sessions and staff said they felt supported in their work.

At our inspection on 5 and 7 August 2015, we identified the provider had not followed the guidelines associated with the use of the Mental Capacity Act Code of Practice regarding the consent of people and what to do when people did not have capacity to consent . This was in breach of Regulation 11 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to say how this was being addressed. At this inspection we found improvements had been made in this area but that but that further work was needed to ensure the capacity of those unable to consent was fully assessed.

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

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Two people were subject a DoLS and applications for further six people had been made to the local authority.

We saw an assessment of capacity had been carried out for one person who was unable to consent to their care and treatment along with a record of a best interests meetings where a decision was made on behalf of a person regarding their medicine. For another person, however, there was a record of a best interests decision regarding covert medicine but this was not based on any assessment of the person being unable to consent to this. Covert medicine is where the medicine is administered by disguising it in someone's food or beverage. Although improvements had been made in this area, further improvements were needed to ensure the consistency of completing mental capacity assessments when considering care and treatment decisions.

We observed staff spent time with people, listened to what people wanted and asked them how they wanted to be supported. We identified care records could be more structured to aid communication with people which may help people understand and contribute to their care planning decisions. We also identified where one person had capacity and said they got the help they needed that the care planning did not show he was fully consulted and involved. We recommend the service develops more effective ways of consulting and gaining the consent of people to their care and treatment.

People's nutritional needs were assessed and were also included in a risk assessment regarding possible malnutrition. People's weight was monitored and a record made of this. Referrals were made to specialist services such as the speech and language therapist where people had difficulty swallowing. Information was recorded in care plans about how people were supported to eat and drink. For example, one person's food was cut into pieces to make it easier to swallow. One person's food and fluid was carefully monitored to ensure they did not eat or drink excessively. This included details about the person's fluid intake and fluid output. However, this was not recorded accurately and did not show the person had sufficient to drink and for the two days preceding the inspection had not been completed. This is included in the Well Led section of this report.

The service previously had a designated cook but this task was now carried out by staff. A relative said they considered the food quality had declined since this was changed but other relatives said the food was of a good standard. The manager said she had introduced a more flexible approach to meals and food which was previously very regimented with strict adherence to meal times and choices. She said people were now able to have treats and snacks. A relative also confirmed snacks were always available. People said they had a choice of food and said they liked the food and one person said how they helped prepare some of the food.

We observed a party taking place at midday when people had suitable food for the occasion. People enjoyed the occasion which was very lively. Staff socialised with people and interacted well with them. Staff gave people support and encouragement to eat and drink.

A community health care professional reported on improvements in the way the staff worked with them. Examples were given where in the recent past staff had failed to carry out assessments and recording charts regarding people having seizures which were now done. The professional said health care records were now up to date and there was effective engagement between health care services and staff. Another example was given where staff attended appointments with a person's neurologist with all the required records to assist the neurologist assess and treat the person whereas in the past staff had arrived without any records.

The manager and staff described how they worked with a person on a gradual basis regarding their dental care. The person had previously refused to allow his mouth and teeth to be examined but now agreed to this. The next step in the plan was to work with the person so they would agree to dental treatment.

Care records showed people's health care needs were monitored by staff and arrangements made for health care checks and treatment. These showed people's physical and mental health care needs were assessed.

Good

Is the service caring?

Our findings

At our last inspection in August 2015 we made a recommendation about ensuring people were consistently treated in a caring and compassionate way. At this inspection we found that improvements had been made in this area.

People said staff treated them well and were kind. One person said they did not have a choice of receiving care from a male or female care staff but this was discussed with the person and staff together and it was evident the person was able to choose.

People and staff had positive working relationships. A relative said people were treated by staff as if they were part of a family and that they observed staff enjoyed working with people, adding, "He's happy. His interaction has improved. He's enjoying his life."

A health care professional told us the staff were "really caring" and knew people's needs well which helped them deal well with any behaviours or a distress. Another health and social care professional said they had observed staff to have a good value base to work with people.

Relatives said people were respected by staff who provided support based on what people wanted. We observed a staff handover meeting between staff leaving and staff starting a shift; it was clear staff valued people who they spoke of in warm and caring terms. The meeting showed staff involved people in decisions about their daily lives and offered them choices. Staff also discussed people's emotional state and how best to support people with these.

We spent time observing people and staff together in the communal areas of the service. Staff were attentive to people's needs and where people had a one to one with staff they were supported well. Staff were warm in their interactions with people, asked people how they wanted to be helped and people were comfortable with the staff who supported them. We also noted staff and people enjoyed their time together and there was much fun, laughter and engagement with people.

The staff recruitment procedure included an assessment of applicant's values so the provider could ensure people had a positive and caring attitude to working with people.

Since the last inspection, concerns were raised by health and social professionals about the approach of staff to working with the people at the service. The manager described how she had taken steps to improve the culture amongst the staff team by promoting a service which reflected what people wanted and had increased choices for people, such as in food and activities. Examples were given of previous structured approaches to meal choices and limited activities due to staff being regimented in their attitudes and unwilling to change. Staff confirmed this had resulted in improvements for people in choices of food and activities. Staff also said these changes had also helped improve people's behaviour and stress.

Relatives said they were able to visit at any reasonable time and said there was good communication with

the staff. The manager and deputy manager said how they communicated with each person's relative by the use of a newsletter giving a summary of what the person had been doing recently such as activities as well as any care needs. For example, one of these included details about the progress a person had made regarding attending appointments with the dentist and activities they attended.

Each person's care plan included details about how to communicate with people and staff had a good knowledge about the most effective way of speaking with people. The manager had introduced some communication tools such as a notice board for people in the communal area but this was not present when we were at the service as it had been damaged by people. The manager stated the notice would be reinstated and a commitment to making improvements in effective ways of communicating with people.

People's privacy was promoted by the staff. We observed staff knocking and waiting for an answer before entering people's bedrooms. People had a key to their room where they were assessed as being able to safely use it. This gave people privacy and security.

Good

Is the service responsive?

Our findings

People and their relatives said care was provided which met people's needs although one relative said they had concerns about how staff managed behaviours which may challenge and that there were not enough meaningful activities. Two relatives said that since their relative recently moved to the service there had been marked improvements in mood and behaviour and that people enjoyed the activities at the service. For example, one relative said, "He has blossomed. His behaviour has improved."

Health and social care professionals gave mixed views about the effectiveness of care at the service. A member of the local authority safeguarding team and two social workers were concerned that behaviours which may challenge were not managed well which had a negative impact on people. Three other health and social care professionals said they considered a good standard of care was provided and that behaviours which may challenge others were managed well.

The inspection of 5 and 7 august 2015 we identified that care and treatment did not always reflect people's needs and preferences. This was in breach of Regulation 9 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to say how this was being addressed. At this inspection we found improvements had been made and the manager and staff were focussed on providing care which met people's needs and preferences, which included improvements in the provision of activities. This regulation was now met.

Each person had care records including assessments of need, care plans and information from referring local authorities and previous health care providers. These included information regarding previous mental health placements and multi- agency planning meetings called the Care Programme Approach (CPA). Two relatives said the staff handled the transition of their relative into the home well which allowed them to settle into the service. This was also the view of a local authority social worker involved in the transfer of one person to the service.

Assessments included health needs, psychological support and mental health, managing emotions, daily living skills, self- care skills, and any spiritual care or cultural needs. There were care plans regarding these needs and for managing people's behaviour. People had behaviour support plans and any behaviour was monitored and reviewed. Care plans included specific to tasks such as supporting people with their personal care with guidance for staff on how to support people. Care plans also included details about people's preferences and choices as well as what people could do themselves. These were included under headings such as 'Individual strengths,' and 'My choices and preferences.' Each person had a person centred care plan. Person centred care focusses on providing care which meets individuals needs and preferences. People were involved in their care reviews where this was possible.

The manager and staff said there had been a concerted effort to improve the quality of life for people by increasing the range and choice of activities for people. The manager and deputy manager said staff had been cautious and reluctant to take people on outings which was addressed with the staff team. Two people had been on holiday supported by staff and this was reported to have been successful. A relative said

plans were being made for their relative to have a holiday. Staff said people now went on outings and holidays which they never did before. A staff member gave examples of trips to the shops, to the zoo and outings. On the day of our visit two people were out with staff at events in the community. Each person had a daily plan of activities both within and outside the home. This increased people's engagement and socialisation with contributed to their overall well-being.

Relatives told us they knew how to raise any concern. Health and social care professionals said any issues or concerns raised were dealt with promptly and effectively.

There were records of five complaints made to the service since the last inspection. A record was maintained of how the complaints were looked into and a response to the complainant. The manager explained how changes were made as a result of the complaint such as the redecoration of a person's bedroom. Therefore feedback and concerns they received were used to improve the quality of the service and meet people's preferences.

Requires Improvement

Is the service well-led?

Our findings

Whilst we noted improvements in the way the service was managed and in the outcomes for people, the operations manager recognised considerable work was still needed. The changes and improvements we noted needed to be embedded and enhanced. For example, the service still had vacancies for five staff. The provider used a monthly audit tool to check on the areas such as staff training, medicines and staff communication, but these highlighted areas where identified actions were not fully completed such as staff training and the updating of care planning for 'as required' medicines. The manager was aware of the need to complete these and expressed a commitment to do so. We also identified records were not always completed where it was important to monitor one person's fluid intake and output. There was a system for looking at trends and patterns in incidents but this was not yet fully implemented and there were still on-going concerns about management of behaviours which challenged others. Annual surveys were used to obtain the views of people and their relatives which the manager said were compiled by the provider but she did not yet have access to the results of the surveys in order to implement an action plan.

The environment was in need of improvement. The previous inspection report identified this as an area for improvement and although the provider said these were to be addressed, at the time of this inspection this action was not completed. The manager said there were plans to completely redecorate bedrooms and communal areas but there were no timescales for this.

The provider did not have systems or processes fully established so the service operated effectively and complied with Regulation 17. This included the operation of a system to assess, monitor and improve the quality and safety of services, as well as the risks to people and for maintaining accurate records. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two health and social care professionals expressed a degree of uncertainty regarding future staffing as two care staff and the deputy manager were working at the service on a temporary basis. Health and social care professionals said there had been a lack of consistency with the staff and management and how important it was to have a settled staff and management team. Concern was also expressed from some health and social care professionals regarding the number of incidents of aggression between people and the number of people accommodated with very high behaviour needs.

Care providers are required to send notifications to the Commission for certain significant events including safeguarding allegations, serious injury and DoLS authorisations. A member of the local authority safeguarding team said there had been delays in notifying them of incidents which needed to be reported to the safeguarding team. We noted there were delays in sending notifications to CQC of incidents involving the safety of people and in alerting the safeguarding team. One example was an incident that had occurred in March 2016 when the safeguarding team were notified 17 days later and CQC 41 days later. More recent incidents have been reported in a timely way.

The manager was experienced in managing care services and was not yet registered with the Commission but their application was in progress. The manager and provider were introducing changes to the culture of

the service, which included the way in which staff worked with people. Staff reported the new manager to be approachable and had introduced changes which had benefitted people. For example, one staff member said, "Supervision is now more frequent. We talk about people's needs. It's getting better. The behaviour of people is getting calmer." Another staff member said, "We're getting better, better and better. Step by step we work out each issue. We work as a team." Staff reported changes had been made which improved the quality of life for people such as increased activities and community access. A health and social care professional said, the service was previously poorly led and that now, "The new manager and deputy are enthusiastic and this has rubbed off on the staff."

Staff meetings and meetings of team leaders were held were held on a monthly basis, which were recorded. The manager said these were used to discuss issues about the service as well as people's care needs and allowed her and the staff to develop a way of working which focussed on a change of culture. The manager completed a monthly audit which covered health and safety and a review of any incidents.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured all service users were protected from abuse. Regulation 13 (1) (4) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises were well maintained, clean or suitable for their intended purpose. Regulation 15 (1) (a) (c) (e) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were systems and processes operated effectively to ensure compliance with the Regulations including the assessment, monitoring and improvements of the quality and safety of the services provided, including the risks to health and safety and mitigate those risks. Accurate records were not always maintained regarding the care of service users. Regulation 17 (1) (2) (a) (b) (c)