One Six One Limited

The Mallards

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The last comprehensive inspection took place on 18 October 2016 and we rated the service as requires improvement in two key questions we inspect against including safe and responsive. This gave the service an overall rating of requires improvement. There were no breaches of regulation. We carried out our latest inspection on 21 May 2018.

The service is registered for up to eleven people with a diagnosis of autism, or a learning difficulty. On the day of the inspection there were eleven people using the service including one person having respite care. The accommodation comprised of the main house and the annex. The service provides both permanent accommodation and temporary, respite care. However, the registered manager said following our visit they were going to cease providing respite care because it is not financially viable.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our inspection visit on 21 May 2018, we found people were happy at the service and were being supported to be independent and engage in different activities. The service was mostly well led but we found the registered manager had been off on extended leave and had only recently returned. In their absence, a number of things had not been fully addressed.

The service managed risk well but some areas of refurbishment and repair in the main house were overdue. Audits were not always identifying issues of concern, which could affect the safety and well-being of people using the service.

Staff felt well supported but there was a lack of recording around formal support, personal development, training and growth. Some staff training was overdue.

People were involved and consulted about their needs and preferences. Reviews established if people were unhappy about any part of the service. The service quality assurance system did not firmly establish how they consulted with health care professionals and other stakeholders or how as an organisation they identified common themes or areas of poor compliance across the services.

The registered manager was well respected by staff, people using the service and relatives spoken with.

They were sensitive to the needs of people using the service and their staff. People received good care and had fulfilling lives.

Staffing levels were appropriate and people received support from regular staff who knew them well. This was a well-planned service where staff were adequately recruited, supported and trained for their job role.

Medicines were administered as intended and audits were designed to identify and address any shortfalls.

Risks were effectively managed for individuals and for the environment. Shortfalls identified were being rectified. Staff understood what constituted abuse and what actions they should take to report abuse and make people safe.

The Commission is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found people's rights were being upheld and staff supported people in lawfully and in line with legislation around mental capacity and deprivation of liberties.
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People were supported to eat and drink sufficient to their needs and involved in meal preparation, menu planning and shopping. People had their health needs met and staff monitored long-term health conditions to help ensure symptoms were well managed.

People's needs were assessed before moving into the service and a clear plan of care put into place. The same process should be followed for people coming in for respite care. People had sufficient occupation, activity and leisure activities.

The service gave people opportunity to comment on the service including having an established complaints procedure and regular reviews of care.

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.

There were enough staff to deliver the assessed care and support required.

People received their medicines as intended and these were administered by competent staff.

The service was mostly clean and well maintained but there was still some refurbishment required in the house.

Staff understood what constituted abuse and what actions they should take to protect people.

Staff recruitment processes were sufficiently robust to help ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff were sufficiently trained and kept up to date with best practice. Staff had opportunity for support but some of this was informal so there was limited evidence of how staff were supported to develop.

People were supported to remain healthy and too see a health care professional when they needed to They were supported to eat and drink in sufficient quantities and access food they enjoyed.

Staff supported people lawfully and understood about mental capacity and when and how they should act in people's best interest.

Is the service caring?

Good

The service was caring.

People's independence and choice was facilitated by staff who

knew them well and had established good relationships with them.

People trusted staff and staff treated people with respect and upheld their dignity.

People were supported to live as they chose and were asked about their preferences, routines and choices.

Is the service responsive?

Good

The service was responsive.

The service assessed people's needs and kept them under review. They were able to demonstrate how they supported people to achieve their goals and to access regular activity. The service supported people for as long as it was appropriate including end of life care and did so by accessing the right support for people.

The service involved people in their care and took into account feedback about the service including having a well-established complaints procedure

Is the service well-led?

Requires Improvement

The service was mostly well led.

People received the care they needed and were happy and settled at the service as were the staff.

The registered manager was supportive of his staff team and worked hard to ensure the needs of people were met. However, we found that the paperwork was not fully up to date neither did it always demonstrate what actions were necessary to improve the service.

There were systems in place to monitor the effectiveness and safety of the service. We identified some gaps in service provision, which did not assure us that the audits were sufficiently robust or that timely actions were taken to address concerns.

The Mallards

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.

The inspection was undertaken by one inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place 21 May 2018 and was unannounced.

Before the inspection, we reviewed information we held about the service including statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. Statutory notifications include information about important events, which the provider is required to send us by law. We used this information to plan the inspection. We received a Provider Information Return (PIR) form. A PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gave the provider an opportunity to provide us with information that was relevant to our inspection.

On the day of our inspection, we reviewed two care plans in depth and referred to others. We reviewed three staff files, spoke with three care staff, the registered manager, the deputy manager, three relatives, and seven people using the service. We looked at audits relating to medication, health and safety, fire safety and cleanliness.

Good

Is the service safe?

Our findings

The last inspection of this service was on 18 October 2016. At this inspection the key question, safe was given a rating of requires improvement. We had found that risks to people's safety and welfare were not always documented to show what actions staff took to monitor and reduce risks to people. At our most recent inspection visit on 21 May 2018, we found staff managed risks to people's safety and this was clearly documented to demonstrate how staff mitigated risk.

We observed care throughout the day and spoke with people about their care and support. Some people were unable to communicate verbally but were able to express themselves through their body language to indicate they felt safe. One person when asked if they felt safe nodded and whispered, "Yes". Another told us they felt safe, a third person said if they did not feel safe, they would talk to staff. Two relatives also stated their family members had settled at the service and they felt able to trust the staff. One relative when asked if their family member was safe said, "100% and more, he's allowed to be himself, he has space. Staff understand his needs. He feels safe there." Another relative said, "Oh I do yes, it's a lovely place. The staff are lovely and friendly and very approachable."

Risks associated with the environment were well managed with one exception. When we arrived at the service, the front door was wide open and there was nothing to prevent us just walking in. The door remained open all day. Staff said they left the door open because it was a hot day. Some people were able to go out independently whilst others needed support due to their vulnerability around other people and concerns about their personal safety. The service was situated on a main road and not everyone was able to navigate the road safely. The open door could pose a risk of a person leaving the service when it would have been unsafe for them to do so.

We reviewed the generic risk assessment for the building and these were satisfactory. There were risk assessments for fire, explosions, burns, scalds, death, personal injury and damage to property. There were clear policies in relation to lone working; on call should staff need support out of hours. There was information around the service about fire safety and actions to be taken in the event of a suspected fire. There was a clear fire plan and evacuation plan. Staff had assessed the needs of people in the event of a fire and individual evacuation plans were in place.

People were encouraged to be independent and staff assessed the risks before establishing what support people might need. Some people were able to leave the service by themselves and access transportation independently. Others needed more support particularly around road safety.

Everyone was assessed as needing support around taking their medication safely except one person who took it with support from their partner. We saw risk assessments in relation to activities of daily living such as personal care/bathing, cooking and access to the kitchen. People's health care needs were well documented and closely monitored to help ensure they were well managed.

Accidents/incidents and any other events affecting the potential or actual well- being of people using the

service were documented and monitored. This helped ensure there was sufficient oversight of actions taken by staff and if these were adequate. Staff said at their monthly staff meetings they discussed the people using the service and any concerns staff might have. They said they reflected on incidents and discussed if lessons could be learnt. Staff were clear about recording accidents/incidents and the use of body maps to record any unexplained bruising or changes to people's skin.

People were protected as far as reasonably possible from the risk of harm or actual abuse. Staff had access to policies, flow charts and phone numbers of appropriate agencies. The flow charts told staff how staff should escalate their concerns. Staff were able to describe different types of abuse and knew what actions they should take to raise concerns. They knew they could raise concerns within the organisation or to outside agencies when appropriate. Staff had completed training in how to safeguard people from abuse. They demonstrated a good understanding of what the training covered. Staff were confident any concerns they might have would be acted upon.

There were enough staff to meet people's individualised needs. Staffing was calculated around people's care needs and activity plan. Some people had one to one funding, whilst others did not. Frequent in house reviews of people's needs highlighted where staff felt people required more support particularly around the provision of activity. This was documented and raised with the Local Authority funding authority. This demonstrated that the service was proactive in trying to secure the right support for people. Staff worked flexibility to help ensure people had sufficient input and opportunity to go out as they wished. Some people's days were more structured than others were and some through higher funding could go out more often. However the registered manager was creative around the use of staffing to ensure everyone had an opportunity to have their individual needs met. The service had a long-standing registered manager and deputy manager; both provided leadership and stability and supported staff as required. At night, there was one waking night staff and a member of staff who slept on the premises for back up as well as an out of hours on call system.

Staff told us agency staff were not used at this service and any extra shifts were picked up by the permanent staff or bank staff who could pick up occasional shifts. This helped ensure people had continuity of care. Staff said rotas were planned to ensure adequate shift cover and staff worked a variety of shifts including one to one hours.

Staff told us roles and responsibilities were clearly defined, and there was good teamwork, which helped ensure everyone got the support they needed. Staff said there was always at least a senior on duty and support from the management team via on-call when they were not on duty.

Staff appeared to work cohesively and provide a seamless service to people. Staff said there was good leadership and they felt supported in their role. Staff had opportunities to reflect on their practice and keep their knowledge up to date. The service had a clock in clock out system, which helped the management team monitor staff's time keeping and safety.

The service had good recruitment processes in place to help ensure staff appointed were of good character and had the necessary competencies. Recruitment files checked included application forms, relevant work history, references, a DBS check, which is a disclosure and barring check. It is designed to check if the candidate had a criminal record, which might make them unsuitable to work in care. It also provided information about whether the person had been barred from working in the care sector. The staff files provided evidence of proof of address and photographic identification. The registered manager explained the interview process and said they did the interviews with the deputy manager. Interview notes were kept demonstrating how the person had met the shortlisting criteria. All new staff were issued a job description

and a contract of employment.

There were safe systems for the administration of medicines. Staff were well trained and received some initial medicines training and then annual refreshers. Staff told us they were supervised when first giving medicines until they felt comfortable. Competency assessments were in place for staff. Staff were supported by district nurses in relation to insulin administration and staff were trained to undertake this role. Staff confirmed that they only administered medicines after their probationary period and once they had received the necessary training.

We looked at people's individual medicines records. There were clear prescribed protocols for medicines prescribed as necessary so staff knew when to administer medicines and what it was for. Medicine records were adequately completed and there were checks on medicine stocks. Creams and ointments charts were signed and dated and stocks rotated to ensure they were used by best before dates. One person administered their own creams, this was clearly recorded, and had been risk assessed. Another person took their own medicines and this had been agreed and established through their initial assessment.

There were audits in place to ensure medicines were available and administered as intended. These were undertaken by the registered manager weekly, monthly and checked annually by an external pharmacist and reviewed periodically by the provider. Staff were clear on actions to take in the event of a medicine error and there were clear records accounting for medicines coming in and out of the service. There was enough personal information about prescribed medicines, what they were for and any contradictions or time sensitive medicines.

There were no pain protocols but staff said people were routinely prescribed painkillers to be administered when required. They said everyone would be able to indicate when they were in pain.

Consent had been sought from people about the administration of medication and it was clear if people had capacity or not. People could take their own medicines if deemed able to do this safely and no one regularly refuses their medicines. There was clear policies and guidance for staff to around the safe administration of medicines.

The service was mostly clean and well maintained. There were no unpleasant odours. We identified a bin in a toilet area without a lid and asked the registered manager to rectify this. We identified a few other areas of concern which were being addressed. Daily audits were completed and a quarterly infection control audit was undertaken. Staff received necessary training on infection control and there were systems in place to reduce the risk of infection or cross contamination such as separate chopping boards for meat and vegetables and sufficient hand cleaning materials and personal protective equipment.

Good

Is the service effective?

Our findings

The last inspection to this service was on 18 October 2016. At this inspection, the key question in effective was given a rating of good. At our most recent inspection, we found the service was still providing an effective service and have rated this key question as good.

People received support around their individual needs and staff were aware of current thinking, policy and practice around working with people with learning disabilities. Staff sought advice from other health care professionals and their training was up to date. Staff had access to policies and procedures, which supported them in their role. Staff had opportunity to reflect on their practice and share ideas with other staff. The service was inclusive and people's individuality was upheld.

We reviewed a number of staff records. These provided evidence of induction, training and support to ensure they had the necessary skills and competencies for their role. The service had details of staff training and a supervision planner. This helped us see at a glance what training they had been done and when it needed to be redone. The supervisions were planned to help ensure they received regular support and any further support needed for their role and personal development could be identified. Staff told us they had both e learning which covered the majority of mandatory subjects and face-to-face training and all said it was plentiful.

The induction record included guidance about health and safety, emergency first aid and manual handling. Staff induction was an initial four day course covering all the necessary training and familiarisation with the organisations policy and practice. New staff were then expected to go through activity workbooks for the next twelve weeks. This was service specific and and helped ensure staff could provide care and support to people adequately. Staff said during their probationary period they were given regular support including shadowing more experienced staff working in each part of the service until they were confident to work independently.

Staff covered all the necessary training relevant to working in the care sector, which included generic courses and courses relating to the specific needs of people they were supporting. Examples included understanding autism, learning disability and mental health, although these had not been completed by all staff. Staff had received training around end of life care.

Staff told us they completed a course around their personal safety, which enabled them to resolve conflict that might arise between people using the service. The techniques taught were to help staff de-escalate a potentially challenging situation to reduce the risk of injury.

People's health care needs were met. We asked people if their needs were met. One person said if they were poorly, they would tell someone if they were unwell. They confirmed staff supported them. Staff told us people had good access to health care and were supported to stay healthy. People used community facilities and regularly saw the dentist and optician. There was good access to the community learning disability team and mental health services. People had annual check-ups, which included a review of their

medicines. Relatives told us they were kept informed of changes to their family member's health and were confident in the service. Records illustrated how people's health needs were met and this was recorded separately in a health action book. The registered manager gave us clear examples of how they had accessed support and therapies for people to build their confidence, self-esteem and fulfil their goals.

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 an assessment shows a person lacks 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 are called the Deprivation of Liberty Safeguards (DoLS).

The service provided staff training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. They had applied to the local authority to deprive people of their liberty where appropriate to do so and with clear rationale. There were clear risk assessments in place on how to support people safely with the least restrictive practice. Staff gave examples of best interest decision taken and why and who was involved.

Staff told us people could make decisions about their everyday care and staff encouraged people to make choices. Information was broken down in a way people could understand. Staff said people might need support with more complex decisions and felt people lacked capacity to make some decisions. They said this was judged on an individual basis with a clear rationale for decision- making. Staff were aware when acting in a person's best interest who they should involve including health care professionals and families who were appointees and advocates who could act on people's behalf. This was documented in people's care plans. Some people had families or a legally appointed person to support them with decisions around their finance, care and welfare.

People were supported to eat and drink enough for their needs. Staff involved people in food preparation, cooking and establishing people's dietary preferences. Staff told us some people's diet had not always been good and the menu not well balanced. This had been addressed with some healthier, low fat options but it was agreed it took time to change people's eating habits. People had opportunity for regular exercise and staff were mindful of promoting a healthy body mass index. People were weighed regularly and there were no concerns about unplanned weight loss. Some people told us they could cook independently; they cooked at college and could go out for their meals or have them at the time of their choosing.

The environment was suitable for people living at the service. In the main house, people had their own rooms and shared communal space. In the annex an additional three people had self -contained accommodation. Staff said the annex was for people who had greater independence. Staff slept on the premises to support the waking night staff and had self -contained accommodation. In the main building, there was a large office, which staff worked from, but people using the service also accessed. The service was well decorated with no obvious odours. We identified internal steps, which might increase the risk of injury. The registered manager agreed they could use something to highlight the edge of the stairs.

Good

Is the service caring?

Our findings

The last inspection to this service was on 18 October 2016. At this inspection, the key question in caring was given a rating of good. At our most recent inspection, we found the service was still providing a caring service and have rated this key question as good.

People were supported with their daily routines and encouraged to be independent. We saw people going out through the day some by themselves, others with staff support. We asked people what they did independently. One person said, "Yes, I do the shopping, I get the food". Another person told us, "I'm volunteering two days a week in a charity shop. I get about, sometimes I walk, I'm independent, and I've got a bus pass." Another person said there were no restrictions and they were allowed to smoke. The smoking area was outside the building so not to affect others. Some people were able to go into town independently and had been assessed as safe to do so.

People told us they did not have a key to the front door and were reliant on staff or would use the back door. Having a key would further increase people's independence. People told us they had keys to their flat/bedrooms. Staff told us and we observed staff offering people day-to-day choices in terms of preferred activity, menu choices and their preferred routines.

The registered manager shared a number of case studies with us with demonstrated how people in the right environment excelled and achieved their goals. For example, they explained how one person when joining the service had high anxiety and low self -esteem. They were supported to go to college to learn skills, which helped them to increase their independence. The service engaged with the learning disability team and accessed psychology support to help them overcome their anxiety and to develop effective coping strategies. They went on to be awarded, student of the year and a local newspaper covered their story.

The registered manager told us about another person who had not had the opportunities to socialise or experience new things. They said on moving in they started to flourish and build up trust with the staff team and become involved in a wide range of activities and were learning new skills which boosted their confidence and independence. When things went less well, the service found an advocate to continue to support and improve the person's opportunities to engage with others and the wider community.

We asked relatives about their family member and if they felt, they had the support they needed. One family member said, "Yes, they encourage them to make their own decisions and make their own meals. They have their own pocket money to go to work." Another relative said, "Yes, they have their own flat and people, (staff) knock on the door".

Staff understood about respecting people's privacy. Staff received training around equality and diversity and respecting people's individuality. The service was extremely personalised and people chose how they wanted their rooms/flats. There was clear guidance in people's care plans about their preferences and what they liked to do some of which included private time. Staff were reminded in the persons care plan to knock on doors and only enter when people gave permission. One person confirmed staff always knocked on their

door and said they could talk to staff privately. Staff said there were always male and female carers on duty so female residents could have a female supporting them with personal care.

There was staff guidance around ensuring people were safe and comfortable and had good well- being. Staff had access to sufficient training, guidance and worked in a supportive environment, which helped to create a nice atmosphere to live and work in.

Staff knew people well and were able to communicate effectively with people and understand their needs and preferences. Some people did not have verbal communication and staff were able to offer choices in a way meaningful to the person through the use of technology, sign language or pictures.

People and their relatives were involved in making decisions about the service and the care they received. They received surveys, which were used to review how the service was provided, and people's satisfaction with it., The registered manager made themselves available and relatives felt able to hold informal discussions with the registered manager or other staff. Care plan reviews were held although families told us they had not seen the care plan.

Good

Is the service responsive?

Our findings

At our last inspection on 18 October 2016, we rated responsive as requires improvement because we found people's care records were not up to date and did not always provide staff with sufficient guidance to provide consistent, individualised care to each person.

At our inspection on 21 May 2018, we looked at two people's care records in depth and referred to others. One was for a person who had used the service for a-long time and was in good detail and provided staff and other professionals all the information they might need in regards to this person. The other care plan was not in sufficient detail. It did not provide enough information for staff in terms of supporting them in a consistent way around their needs and associated risks. Staff confirmed most care plans were fully up to date the exception was for a temporary resident.

The first care plan included a one- page profile and gave a good initial oversight of the person's needs and what they could do for themselves. It included what a good/bad day would look like for them including information about their routines, interests and hobbies. It gave financial information and what support they needed. It gave any relevant health information and support the person might need to maintain their current health or manage/monitor any pre-existing health conditions. There was a keep healthy folder so everything about the person's health care needs were recorded in there. The care plan also included a: circle of support with detail about the person's family tree and who was important to them.

The first care plan made it clear what the person was able to do for themselves, any risks associated with their care or the choices they made. We saw an example in one person's care plan that the risks of smoking had been considered in relation to their health and fire safety.

In the first care plan there was consideration for the person's leisure time and what they were expected to do at home to contribute to the running of it such as assisting with their laundry, meal planning/cooking and keeping the service clean.

Other care plans reviewed had clear communication plans, which recorded people's understanding and use of language to communicate their needs. Some people had complex communication needs as they were non-verbal but staff were clear about what their needs were and how they would communicate their everyday needs and wishes. Some people used tablets/ computers, which had communication apps and plans stated if people could read/write and if they were able to comprehend information or how staff should facilitate this. Some people used Makaton sign language and staff were familiar with this.

There was guidance around behaviours and what might upset people and how staff should respond to this. For example, one person did not like too much noise. The guidance spoke of how to deescalate negative behaviours in a positive non- physical way. Staff said people could sometimes get upset or exhibit behaviours, which might put them at risk. They said there was input from social workers, psychologists and social services.

Reviews showed us what people had achieved against agreed goals, for example, goals were agreed in all areas of the person's life, at home, day placement or wider goals such as holiday choice. One person wanted to move out and staff said they were supporting them to be more independent. Each month staff allocated to a specific person known as their keyworker updated the person's plan of care. The registered manager said this was done in discussion with the person and goals were identified around people's needs and wishes. These would be kept under review to record the progress made against each goal. The meeting would be an opportunity for people to discuss what they would like to do in the preceding month.

The second care plan we looked at was for a person who had newly joined the service. However, despite them being there for a couple of months, there was no real guidance for staff other than their initial assessment, which highlighted a lot of needs and risks associated with this persons care and support. Staff had a good understanding of the persons needs and were supporting them appropriately. We could not see how risks to this person's safety and to staff and other people using the service were being adequately managed. This was because there were no clear protocols in place advising staff what actions they should take in different situations. The registered manager was clear that there was regular communication with the care manager and any risk or gap in provision was reported and managed through a multi- disciplinary approach. They explained the person came to the service in an emergency and was not meant to be permanent. We pointed out the importance of having clear plans in place to demonstrate how they were adequately supporting the person and meeting their assessed needs and risks. However, we found overall care plans were of a good standard and we did not see any evidence that people's needs were not being met.

Some people were not able to tell us about their experiences because of limited verbal communication but nodded to our questions or answered yes and no. However, several people were able to respond in depth. One person told us they enjoyed the cinema and had recently been. They said they liked all the staff and went out with them for a walk or to buy clothes. They said they attended day centre and helped in the house. They said staff helped with cooking and they did too. They told us they had a key to their rooms and enjoyed going on holidays.

People were supported to stay active and pursue their interests. On the day of our inspection, some people were out at day centres, colleges, out with staff or family members. One person did some volunteer work. One person went food shopping with staff and everyone had some activities they were engaged with. We saw a lot of energy at the service with people being busy and engaged and a lot of interaction between people and staff. There was evidence of clubs and weekend activities people attended. There was lots of photographic evidence of people enjoying different activities and accessing the local town and resources. Some people were supported to go to their parents at the weekend and maintain contact with other family members and friends. The registered manager said no one went on holiday last year but they were looking to plan holidays this year and people went on day trips. Staff spoke enthusiastically about the different things people did and accessed during the week. Staff demonstrated that they knew people well and planned trips out in line with people's interests and hobbies and made use of local resources and events. Examples given were the local steam fair, swimming, banger racing and football.

No one at the service was receiving end of life care. However, the service kept people's needs under review and adapted the service and the support they received to ensure their needs were still being met. They worked with other health care professionals and gave staff the relevant training to support people for as long as appropriate. This included end of life care. The records we saw did not discuss people wishes in relation to their end of life care. This should be addressed at an appropriate moment and ensure there is adequate future planning.

The service had an established complaints procedure, which was accessible. People and relatives spoken with were happy to raise concerns and felt the manager was approachable. Compliments and reviews of the service was seen. We asked people if they were happy with the service and one person raised concerns about their care and support. Staff were already aware of their concerns and were working with them to resolve these. The details of their concerns were not adequately recorded so we could not see actions taken by staff, although they were able to confirm they had taken appropriate actions. We had asked the person if there was regular opportunity for them to talk to staff, which they agreed there was but said there were no house meetings, which they felt, might be a good idea. They suggested other people had similar concerns to them, which had not been explored. They did however say they had individual meetings with their key worker.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 18 October 2016, we rated well led as good. At our latest inspection visit we identified some concerns, which had not been identified by the service, so have rated this key question as requires improvement.

We found there was an experienced registered manager overseeing the service on the day of our inspection visit. An experienced deputy manager with thirteen years' service supported them. Staff continuity was good and most staff had relevant experience and additional qualifications in care. Staff spoken with were enthusiastic and motivated. One staff told us, "100% support, work together, I absolutely love it, it's so rewarding I wouldn't do anything else." Another said, "We promote people's independence, it's amazing". All staff spoken with were confident in the registered manager and said if they raised anything it was dealt with. The outcomes for people were good and they received appropriate support and opportunities around their assessed needs.

However, we found monitoring systems were not always effective in identifying and demonstrating how things had been addressed in a timely fashion. For example, we found staff training was not all up to date. Staff could not start work until they had completed relevant mandatory training such as manual handling. However, some of their refresher training had not been completed within the agreed timescales. The registered manager was addressing this and had prompted staff to complete relevant training. Staff were not receiving an annual appraisal of their performance or having the number of required supervisions of practice as stipulated in the company's supervision policy of six a year. There were 27 staff employed and the staff we spoke with said they were well supported. Following our visit the registered manager told us they had implemented an annual supervision planner for all staff with planned supervisions commencing with effect from July 2018 (including scheduling in an annual appraisal). The registered manager had not yet had an annual appraisal of their performance but said this was planned. Some staff had not completed additional vocational courses in care despite their request, but we were informed there was an issue around funding. The registered manager had not completed the registered manager's award or equivalent, but the organisation had a management development programme, which provided units of study relevant to the management role.

The person admitted to the service recently did not have a clear plan of care or associated risk assessments. The registered manager was aware this should have been done and said they would address it immediately. However, they assured us that despite a lack of documentation there was regular input from other professionals and staff to ensure their needs were managed and risks reduced.

We noted in the main house some areas of the environment which could increase risk to people such as the front door being left open all day. We found in one of the bathrooms due for refurbishment, the floor was stained, the extractor fan dirty and there was inadequate sanitation. The last infection control audit had been completed in April 2018, and highlighted some of these issues but they had not been rectified. However staff had received infection control training and there was some ongoing refurbishment planned. There were ongoing problems with the wet room and a persistent leak. We reviewed a number of audits,

which had identified concerns. For example, the food safety officer raised some concerns in January 2018 about food temperatures and the safe storage of foods. They found things were not always labelled when opened or stored correctly in the fridge. The service had rectified the issues identified but had not identified these issues for themselves.

The last financial audit for the whole service was dated January 2017 so was overdue but there were monthly audits of people's finances to ensure receipts were kept and the balance tallied with what was recorded. We saw checks and risk assessments in place for the prevention of legionnaire's disease. Water temperature checks were carried out. One such check highlighted that the temperature of a shower had exceeded the recommended temperature and had been reported to the registered manager. We could not see what action they had taken to reduce the risk of scalding to people using the service. Following our visit, the registered manager confirmed temperatures were taken monthly and the latest audit had highlighted two showers, which were exceeding recommended temperatures, and this had been recorded on the maintenance report and forwarded to the relevant team for actions. What it did not tell us was what immediate action was taken to ensure people's safety. We noted window restrictors were fitted to prevent windows opening fully and these were audited by the maintenance team. We have asked the registered manager to update of the actions they have taken to date.

We spoke with the registered manager about our findings. They told us they had been off sick for quite a while and although the deputy manager managed the service in their absence, they had some things they needed to catch up on since their recent return. They also managed a second service down the road, which had a smaller number of people. The registered manager worked hard but had competing priorities and worked in a busy office with lots of interruptions from people using the service. The registered manager clearly prioritised and focused on the experiences of people and less so on administrative systems. We found the records difficult to access due to the quantity of information kept. There was no administrator, which might assist in ensuring all the paperwork was up to date. The registered manager's posts was not backfilled when they were off.

The registered manager told us they attended monthly registered managers meetings but the service was geographically far removed from other services in the region. They had limited contact with local care homes or the registered manager forum held locally which helped managers keep in touch and provide mutual support and learn from each other's experiences. The registered manager opportunities for support outside the organisation were not formally developed and they said they had insufficient time for this.

The registered manager confirmed they audited their service and had an action plan which documented improvements they were required to make against their timescales of compliance. The registered manager submitted a service development plan quarterly. The manager confirmed they were supported by the registered provider who carried out audits in line with the action plan submitted by the registered manager. This provided evidence of how the service was meeting the key lines of enquiry that CQC use as a benchmark of compliance and to award the service a rating. The registered manager needed further support to ensure actions identified as part of the quarterly audit were up to date. It was not clear how this was achieved or how they were supported by the wider organisations whilst they were off.

The organisation communicated with its staff through newsletters and regular updates. There was a company magazine and award ceremonies to promote and celebrate good practice and innovative ideas.

Families were happy with the service but not all were able to tell us if they had been involved in care reviews or asked to provide feedback about the service. Surveys were sent out this year but at the time of inspection they had only been sent out to people using the service, further surveys were still to be sent out. The

registered manager said when this is done and they have received feedback they would collate and analyse the results and give feedback. The registered manager does this and not the wider organisation so we could not see how this feeds in to the wider organisation quality assurance programme.

There were monthly audits and information recorded in relation to risk associated with the care provided or the environment in which the care and support was provided. There were very few recorded incidents but all were adequately recorded with actions taken.