The Together Trust

Pearce Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This unannounced inspection was carried out on 12 August 2016. The service was last inspected in September 2014 and the service was found to be compliant in all the regulations in force at that time.

Pearce Lodge is part of the Together Trust which is a registered charity. The home provides support for up to five people who have a physical and/or a learning disability. All bedrooms are located on the ground floor with the first floor providing staff sleeping facilities and office space. The property is situated in a quiet residential area off Hazel Grove, Stockport and is close to local amenities. On the day of this inspection four people were using the service.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care Quality Commission (CQC). 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.

One person using the service required significant levels of one to one supervision and the registered manager had not applied for a Deprivation of Liberty Safeguards (DoLS) authorisation, therefore the Mental Capacity Act 2005 (MCA) guidelines were not being fully followed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the registered provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support. However, we found that the systems failed to identify that staff did not receive regular supervision and appraisal and that one person using the service had not been referred for a DoLS asessment. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the service deemed essential. This included the Positive Range of Options to Avoid Crisis and use Therapy – Strategies for Crisis Intervention and prevention UK (PROACT-SCIPr-UK) programme. However, staff did not receive regular supervision and appraisal. We made a recommendation about supervision in the report.

We found there were sufficient numbers of staff on duty to meet the needs of people living at the home. However, the service currently had four full-time vacancies for care staff and were reliant on agency staff to ensure that sufficient staff were on duty.

We found that staff had a good knowledge of how to keep people safe from harm and we found that the recording and administration of medicines was being managed appropriately in the service. Staff had been

employed following appropriate recruitment and selection processes.

Assessments of risk had been completed for each person and plans had been put in place to minimise risk. The service was clean, tidy and free from odour and effective cleaning schedules were in place.

People's nutritional needs were met. We saw people enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day. One person told us they were well cared for and we found people were supported to maintain good health and had access to services from healthcare professionals.

Staff were knowledgeable about the people they cared for and they interacted positively with people living in the home. People were supported to make choices and decisions regarding their care.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported.

People were offered a variety of different activities to be involved in. People were also supported to go out of the home to access facilities in the local community.

The registered provider had a complaints policy and procedure in place and there were systems in place to seek feedback from people and their relatives about the service provided.

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.

Staff displayed a good understanding of the different types of abuse and had received training on how to recognise and respond to signs of abuse to keep people safe from harm.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service. However, the service was currently dependent on agency staff to maintain staffing levels.

Risk assessments were in place and reviewed regularly, which meant they reflected the needs of people living in the home.

The home had a robust system in place for ordering, administering and disposing of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager had not applied for a Deprivation of Liberty Safeguards (DoLS) authorisation for one person using the service, therefore the Mental Capacity Act 2005 (MCA) guidelines were not being fully followed.

Staff had received an induction and training in key topics that enabled them to effectively carry out their role. However, regular supervision and appraisal was not completed.

People's nutritional needs were met and when required, they received additional treatment from healthcare professionals in the community.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs.

People were offered choices about their care, daily routines and food and drink whenever possible.

Is the service responsive?

Good

The service was responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

We saw people were encouraged and supported to take part in a range of activities.

There was a complaints procedure in place and people were encouraged to comment on the quality of the service they received.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's governance systems had failed to identify shortfalls in Deprivation of Liberty Safeguards (DoLS) authorisations and staff supervision arrangements.

People told us they found the registered manager to be supportive and felt able to approach them if they needed to.

There were opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Pearce Lodge Care Home

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 August 2016 and was unannounced. One adult social care (ASC) inspector carried out this inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection, we spoke with four members of staff, the registered manager, one person who used the service and one social care professional. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, medication records for four people, handover records, supervision and training records for three members of staff and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

The one person we spoke with told us, "It's a really nice play to live, I always feel safe when I am with the staff, I don't have any worries."

People who used the service were protected from abuse and avoidable harm by staff who had been trained to recognise the signs of potential abuse. Staff we spoke with understood how to report any safeguarding concerns and told us they were confident the registered manager would take the appropriate action if they reported any episodes of poor care. One member of staff told us, "I have reported an issue in the past, I discussed it with the manager and they addressed it with the person responsible." Another said, "I've not needed to raise any issues but if I did I wouldn't hesitate to discuss it with the manager." We viewed training records and found that staff had completed training in the safeguarding of vulnerable adults.

The registered provider had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the registered manager used the local authority's safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We observed that safeguarding concerns were recorded and submitted to both the local authority safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents. We noted that one recorded incident involving an agency member of staff during the provision of personal care had not been submitted to the safeguarding team. We discussed this with the registered manager who informed us that, because a permanent member of staff had intervened and corrected the person's practice before any harm had occurred, it did not trigger a referral. We discussed the need to develop a 'safeguarding consideration log' to ensure that the decision making process was recorded for all potential safeguarding concerns.

Accidents and incidents were well recorded and included body maps to ensure that any injuries sustained were documented and appropriate action could be taken. Completed accident / incident forms were sent to the head office for auditing each month. The process of auditing enabled the registered provider to check for any recurring incidents or any patterns in time or day when accidents took place. We also saw that the recording of restraints was thorough and included information in relation to the time, location and duration of the incident and which members of staff were involved. The registered manager was required to sign the record of each incident of restraint to confirm they were satisfied with the actions taken by the staff involved.

The registered provider had systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs and individual behaviour support plans to advise staff on how to manage any anxious or distressed behaviour. They also identified that regular reviews of both physical and mental health were necessary to ensure people's changing needs were met. We saw Personal Emergency Evacuation Plans (PEEPs) were in place for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This showed us that the registered manager had taken steps to reduce the level of risk people were exposed to.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, gas safety, fire extinguishers, emergency lighting and all lifting equipment including hoists. A suitable fire risk assessment was in place and regular checks of the fire alarm system were completed to ensure that it was in safe working order. We found that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. Weekly and monthly maintenance checks of the building were completed and this included tests of the fire alarm, carbon monoxide detectors, emergency lighting, fire door seals, self-closing doors, smoke alarms, water temperatures and vehicle checks. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We discussed staffing levels with the staff. One told us, "A lot of staff have left and they've not really been replaced. We use a lot of agency staff now and some are better than others, but they cannot carry out the more specialist tasks that the full time staff can. We sometimes only have one person on shift who is trained in all the different techniques such as the tracheotomy care we use with our service users. I'm not saying that people don't have their needs met, but it increases the stress and pressure on staff and makes you feel a bit vulnerable. I know they are recruiting but it seems to be taking forever."

The registered manager told us that the regular staff were a real asset to the service and they were in the process of advertising for new staff of a similar quality to the staff already employed. At the time of this inspection the service was dependant on the use of agency staff to ensure there were sufficient numbers of staff to meet the needs of the people they supported. When agency staff showed the required qualities they arranged short term contracts with the agency to guarantee the same regular agency staff attended each week. This ensured that people were cared for by staff that knew their needs as often as possible. We viewed the weekly operational manager's update and found that the number of vacancies currently stood at four. Prior to the report being published we spoke with the registered manager and they confirmed they had recently appointed two new full-time members of staff and interviews had been completed for the final two vacancies.

From speaking to staff and our observations on the day of the inspection, we found there were sufficient numbers of staff to meet the needs of people and any shortfalls were in the process of being addressed.

We checked three staff recruitment files and saw that appropriate checks were completed before staff commenced working within the service. Application forms were completed, interviews carried out, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Some of this information was held at the head office to ensure confidentiality and was submitted to us after the site visit. Staff were provided with job descriptions and terms and conditions of employment. This helped to ensure staff knew what was expected of them.

We looked at how medicines were managed within the home and checked four people's medication administration records (MARs). We saw that medicines were obtained in a timely way so that people did not run out of them, were stored securely, administered on time, recorded correctly and disposed of appropriately. Some people who lived at Pearce Lodge had been prescribed controlled drugs (CDs); these are medicines that have strict legal controls to govern how they are prescribed, stored and administered. There was a suitable storage cabinet and staff were recording the administration of these medicines in a CD record book. We checked a sample of CDs held against the records in the CD book and found that these

balanced.

We saw that medication was audited weekly and included stock checks of medication. If any medication incidents or discrepancies were noted then a form was completed and the registered manager was required to sign to indicate they had reviewed the issue and were satisfied with how it had been resolved. We noted that on some occasions the air temperature of the medication room was close to the maximum 25°C limit and this might need to be monitored in the warmer months to ensure that the medication was not stored above recommended temperatures.

During the inspection we found the home to be clean, tidy and free from odour. Cleaning schedules included daily, weekly and deep cleaning tasks to be completed by the staff. This showed us that the registered manager had considered the impact of infection for people in the home and had put interventions in place to minimise this risk.

Requires Improvement

Is the service effective?

Our findings

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 so that they can 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager informed us that they had not made applications for a DOLs authorisation for any of the people using the service at the time of this inspection. However, we found that one person using the service was provided with 16 hours of one to one supervision each day and this included periods of two to one support. Although they were able to spend time on their own, throughout these periods they were monitored via a sound monitor and regular visual checks by staff. The person also required the use of both a lap belt when using their wheelchair and an adapted bed to ensure they were safe from falls. The person was assessed as lacking the capacity to consent to the plan of care in place and required full supervision whenever they left the service to access the community. This failure to seek DoLS authorisation meant that the principles of the MCA were not being followed.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safeguarding service users from abuse and improper treatment).

Following the inspection the registered manager reviewed all of the people using the service in relation to DoLS and made referrals for assessment for two people.

Staff had completed training in relation to the MCA and DoLS and they understood how to gain consent from people before providing care or support. Support plans provided details of what decisions people using the service were able to make for themselves, the decisions they required support to make and which decisions were made on their behalf. We saw that assessments of people's capacity had been made under the MCA for specific decisions such as finances, holidays, appointments, activities and day trips. When it was deemed that people lacked the capacity to make an informed decision, a best interest meeting was held. Best interest meetings are held when people do not have capacity to make important decisions. Health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

We discussed the use of restraint with the registered manager and the staff team and they told us that this was always done as a last resort and all interventions were carefully planned. We saw that all staff involved in any incident of restraint had completed both theoretical and practical training in the British Institute of Learning Disabilities (BILD) approved Positive Range of Options to Avoid Crisis and use Therapy – Strategies

for Crisis Intervention and prevention UK (PROACT-SCIPr-UK) programme and this was refreshed on an annual basis. This course provides a holistic approach to the management of people's behaviour and aims to minimise the use of physical interventions and emphasise behaviour support strategies which are based upon an individual's needs, characteristics and preferences. All restraints were planned in agreement with a PROACT-SCIPr-UK trainer, and other relevant people and professionals.

We viewed restraint records and saw that one person had experienced a high number of restraints in a two month period. The registered manager explained that when the person initially moved to the service they had a period of heightened anxiety that resulted in nine restraints in a period of two months, with the last restraint recorded in April 2016. All of these restraints lasted less than two minutes and were predominantly used to prevent injuries caused by self-harming behaviour. The registered manager explained that as part of the person's transition into the service they had identified three members of staff who could move from the person's previous home to Pearce Lodge to provide continuity of staff. This helped ensure that the person's behaviours did not escalate to the levels observed at the person's previous placement. Staff told us as the person had become more accustomed to the service and members of staff, their anxiety levels and associated behaviours had started to subside and the number of incidents of restraint had decreased. This was confirmed by a social care professional who told us, "I was very pleased with how much [name of person's] social skills had developed. They were able to sit with me and hold my hand without getting anxious. They are making some good progress."

Staff had the skills to communicate effectively. During the inspection we spent time observing the interactions between people who used the service and staff. Staff supported people and understood their individual needs. Staff described people's non-verbal communication methods and explained what gestures, noises and facial expressions meant. We saw that staff could also refer to people's care plans for guidance regarding this. For example, one person's care plan stated, 'I am unable to communicate verbally. I will express that I am happy by initially greeting staff by sniffing their face, nose and skin. I also rub noses with staff."

We asked one person whether they felt the staff were well trained and competent when providing care and they said, "Yes, all the staff are well trained - they all know what they are doing."

We viewed staff training records and saw that all new staff completed an organisational induction, which included the shadowing of more experienced staff. Staff had completed a range of training pertinent to their role such as administration of medication, safeguarding, and moving and handling. Further training required to support the individual needs of the people who used the service including gastroenterology, tracheostomy and ventilator care had also been undertaken. The registered manager told us that when a person moved into the home staff would complete the relevant training so that they were able to meet the person's assessed needs.

We spoke with a member of agency staff and they told us that they did not to carry out all of the tasks that the full time staff were trained to complete. They told us, "I shadowed full time staff to help learn people's routines and any behaviour I need to be aware of. I don't administer medication, do suction or support with gastro care so don't need the training for that." Another member of staff told us, "I'm happy with all of the training I receive, I feel it's good quality."

We found the frequency and quality of recording of staff supervision and appraisal was inconsistent. We saw that one person had not had supervision for over a year, although when they raised a concern supervision did take place. Another member of staff said, "I can raise issues, but I've not had any formal supervision as such." We discussed this with the registered manager who acknowledged that some supervision had fallen

behind schedule, although they were in the process of addressing this and we saw some evidence to confirm that the process of supervision had restarted.

We recommend that the registered provider review their own staff supervision policy and its application across the staff team.

We were told that three of the people using the service received all of their food, fluids and medication through a Percutaneous Endoscopic Gastrostomy (PEG) tube. A PEG tube is a feeding tube which passes through the abdominal wall into the stomach so that food, water and medication can be given without swallowing. Staff followed guidelines to ensure that these people received the correct amount of 'feed' to make sure they had the required number of calories and nutrients to meet their nutritional needs. We saw this information was recorded on the person's medication administration record.

One person who was able to eat a typical diet was encouraged to make positive food choices where possible. They had specific cultural needs in relation to food that had to be adhered to and this meant they had separate food storage areas. We saw they had a detailed plan of care pertaining to their nutritional needs and this required the staff to 'plate up' the person's food and allow them to sniff the food before encouraging them to sit at the table. The plan explained that if the person was feeling anxious it was less likely that they would want to eat at the table and they should then eat whilst sitting on the couch to ensure they were consuming adequate amounts of food and drink.

People were weighed regularly to ensure any issues with their weight were identified and action could be taken. The registered manager told us, "It's important that we monitor people's weights on a regular basis. Our wheelchair users seats are individually moulded, so any weight fluctuation can have an impact on how comfortable and safe they are when using their wheelchair. If we have any concerns regarding people's weight or appetite then we always contact the GP or make a referral to the dietician."

A range of health and social care professionals were involved in the holistic care, treatment and support of the people who used the service. The care and support plans we saw indicated advice and guidance had been provided by community nurses, occupational therapists, speech and language therapists (SALT) and care co-ordinators. People were supported to visit or be visited by GPs, opticians, health screening teams and chiropodists. This provided assurance people's healthcare needs were consistently met.

People's rooms were decorated to their liking and where possible people were consulted regarding the decoration of their room, enabling them to choose their own bedding, curtains and accessories. One person who used the service told us, "I chose the colour of my room and also helped do some of the wallpapering." To the rear of the home was an accessible garden area, which was paved and had a number of planters that people had painted and these were filled with different flowers. The registered manager explained, "We paid for the paving of the garden through the sponsorship money we raised when we did the great north run."

The registered manager explained that storage within the home was something of an issue, as a number of the residents had large items of equipment. They showed us a sensory room that included various pieces of sensory equipment including lighting, music and adapted furniture. However, the room also housed unused equipment; this meant that although people could use this space, it was not as accessible as it could be. The registered manager told us there were plans in place to increase the size of the home, which would alleviate these issues. However, there were no fixed dates for this work to begin.

Good

Is the service caring?

Our findings

We observed that where possible people went about their daily lives and moved around the home as they wished. People chose when they wanted the company of staff and would make their feelings known if they wanted time away. When people were unable to move around the service by themselves staff explained how they tried to ensure they spent time in an environment they were happy with. For example, during the inspection, one person became vocal and a member of staff told us, "This could mean they want to spend some time in their room. What I usually do is take them to their room and let them have a lie down. If they settle down then I leave them to rest, if they continue to be vocal then I have to try something else. It's trial and error sometimes, but the longer people are with us the more you get to know them and the more often you get it right."

Staff told us how they tried to ensure that people were given a choice over their care even when the person was unable to effectively communicate all of their needs. A member of staff told us, "We look at people's body language, look how they respond to different options and choices. [Name of person using the service] will take you and show you what they want" and "We can use yes and no cards to find out what activities people want to do or what they would like to eat." We saw that care plans provided clear guidance on how to effectively communicate with each person using the service. This included looking for specific actions, noises or behaviours to indicate what support or item the person might require. A social care professional we spoke with told us, "At the recent review it was clear that [name of person] was able to make more choices for themselves. They were choosing their own breakfast and making decision about what clothes to wear.

Some of the people who lived at Pearce Lodge used objects of reference to aid communication between themselves and the staff team. An object of reference is any object which can be used systematically to represent an item, activity, place, or person. Objects of reference were used to signal the beginning of a new activity, identify if the person required a specific personal care task to be completed and to help people using the service to make their own choices in relation to what activities they would like to do. For example, one person used a pink 'scrunchie' to indicate that it was time for a bath or a shower. This showed that the service were open to new ways of communicating with the people in their care.

Staff told us they actively encouraged people to do as much as they could for themselves. For some people using the service there were very few tasks they could do independently, however we saw staff still supported them to try. Comments included, "We know what they [people who use the service] are capable of and know when it's the right time to push them to try something new. [Name of person using the service] can be up and down so we need to time it right, build them up and try and develop their skills" and "I always encourage [Name] to complete some of their personal care. When I'm washing their hair they can rub the shampoo in and choose which products they want to use."

People were treated with dignity and respect. We saw that staff knocked on people's doors before entering, called people by their preferred name and ensured bathroom doors were closed quickly if they needed to enter or exit, so that people were not seen in an undignified state. They also ensured that they did not

provide any care considered to be personal in the communal areas when other people were present.

People were allocated key workers who were responsible for ensuring that people's care files were kept up to date, their rooms were deep cleaned on a weekly basis, the condition of clothing was checked, all appointments were entered in the diary and that they had sufficient toiletries. They also supported people to access the community when they were on shift. Having an allocated key worker helped ensure that a specific member of staff was accountable for completing tasks the person was unable to do for themselves.

Good

Is the service responsive?

Our findings

We saw that people using the service had placement reviews on an annual basis and that relevant people including relatives, advocates and health and social care professionals were invited to attend. We also saw that care plans were reviewed three monthly and updated whenever a person's needs changed. One person who used the service told us, "Yes, I have regular reviews at least once a year, they invite my family and we discuss how things are going."

Highly detailed support plans had been developed from information gained during initial and on-going assessments, discussions with people's relatives, local authority care plans, health and social care specialists and from observation made by staff when they were supporting people. Support plans included meticulous detail regarding all aspects of a person's life and what tasks people could carry out independently. Each support plan was written in a person centred way and clear goals were identified for each specific element of the care plan; this enabled all relevant people involved in the persons care to measure how effective the placement was.

People had individual behaviour support plans in place to inform staff how to best support people during periods of heightened anxiety and distress. These plans provided detailed descriptions of proactive, active and reactive strategies that could be employed to help manage a person's escalating behaviour. Triggers and early warning signs were identified and approved staff responses were listed under each strategy. When physical restraint was required, comprehensive restrictive intervention plans identified the minimum number of staff who should be involved at each level of intervention ensuring that the minimum amount of force was used. People also had restrictive intervention reduction plans in place to further guide staff in methods and techniques to reduce the frequency that physical intervention was required. This meant that staff had clear guidance on how to effectively manage a variety of different behaviours.

Care plans were made available to agency staff so they could gain an understanding of each person's needs. Due to the depth of information available, we felt that an abbreviated version of the care plan would have been beneficial. However, all agency staff were given opportunity to shadow a more experienced member of staff before they were expected to provide any one-to-one support, and this helped them to get to know people's individual needs.

The registered manager explained that they encouraged all people who use the service to engage in education and learning and we were aware that some of the people who lived at the service were currently attending college or day centres. The courses people attended were designed to develop the individual life skills of each person to encourage them to meet their own potential. Individual activity programmes were developed to ensure that people were engaged and occupied in activities of their choice.

We saw that people had weekly activity planners in place. One person using the service had chosen a variety of activities for the week including trampolining, baking, disco night, family time, youth club and shopping. We viewed the person's monthly activity for August and found that they had already completed a number of activities including a visit to Manchester, disco, pub, home visit, film night, baking, trip to Buxton, and

numerous walks to the local shops. A member of staff explained that, as it was the college holidays, additional activities had been provided to keep the person occupied and this was confirmed by a social care professional we spoke with.

We were told that all of the people using the service had the opportunity to go on holiday and that they often chose to go to a log cabin in Derbyshire and also had access to a caravan. These locations were fully adapted and this meant that people using the service could enjoy a break from their usual surroundings in a safe and comfortable environment.

The registered provider had a complaints policy and procedure in place and we saw that this was displayed throughout the home and on the Together Trust website. It was also included in the service handbook that was distributed to people and their families.. The policy explained the timescales for raising, acknowledging and responding to any complaints and provided details of how the complaint would be escalated within the registered provider's organisation if the complainant remained unhappy with the outcome of any complaint. We saw that the complaint policy encouraged people to make suggestions regarding how the service could be improved and provided contact details so people knew who to speak with. However, we noted that the complaint policy did not signpost people to external agencies who could assist them in making a complaint including the local authority or local ombudsman. We discussed this with the registered manager who informed us that they would ensure this information was fed back so the policy could be updated.

We viewed the complaint file and found the last recorded complaint was received in July 2012. The registered manager explained that not all of the people who used the service would be able to raise a formal complaint; however, they were able to indicate whether they were happy, content, sad, anxious or excited through individual behaviours, facial expressions and physical contact. A member of staff said, "We look at how well people are sleeping, how compliant they are with care and their general mood to help us assess how happy they are or whether something is causing them more anxiety." One person who used the service told us, "I've never complained, but if I had any issues I would speak with [Name of manager] or [Name of keyworker]." We spoke with one person's social worker and they told us, "We held a review recently and no concerns were raised by the family. They are currently pleased with the way the service is meeting [Name of person's] needs and gave positive feedback."

People who used the service were offered other opportunities to provide feedback regarding the service. This included meetings with each person who used the service every Sunday and house meetings. Different topics were discussed and the staff present would look at each person's response to each topic or discussion to gather an understanding of whether they were in agreement. Staff told us "We give two or three choices and then gauge people's response to see whether they are agreeable with the suggestion. We know people so well; we like to think that we are able to get it right. If we don't we soon know by their response. We record this and then make sure we try something different next time."

Requires Improvement

Is the service well-led?

Our findings

Although a quality assurance system had been developed, we found the system was not always effective. The system had failed to identify that staff had not received regular supervision in line with the registered provider's supervision policy. We also found that the registered provider and registered manager had failed to seek Deprivation of Liberty Safeguards authorisations for one person using the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, (Good Governance).

At the time of our inspection the service had a manager who was registered with the Care Quality Commission. The registered manager had been employed by the service for over 15 years which provided some stability to the service. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of the regulations and we saw that they were appropriately maintained, up-to-date and securely held. This meant that people's personal and private information remained confidential.

Staff we spoke with told us that although they had not received formal supervision they felt well supported by the registered manager and they were able to approach them with any issues or concerns they may have. Team meetings took place and staff told us that these were a good opportunity to discuss each person using the service and identify any changes in needs. Staff also told us that they used the meetings as an opportunity to refresh any training such as medication or tracheotomy care.

'House meetings' were held weekly and these provided people using the service with an opportunity to express any concerns or raise any issues. We saw that topics discussed included any issues raised at the staff meeting (where appropriate), activities, any required personal items and the weekly menus. People's relatives were free to visit the service as often as they liked and staff told us they were always available to record any feedback. We noted that there were no recent quality assurance surveys completed by any of the stakeholders involved in the service. This meant that an opportunity to gather valuable feedback about the service had been missed.

The registered provider had a clear vision, set of values and a mission statement. It stated, 'Our mission is to offer an equal chance in life. We believe everyone has the ability and the right to experience joy, happiness and hope, and we do everything in our power to make that happen.' The service recorded values such as Positive, Professional, Passionate and Supportive as core to the service and the way in which they operated their business.

We saw there was a quality monitoring system in place that consisted of weekly, monthly and annual audit

tasks that were completed by the staff and registered manager. Information collated from these was analysed and action plans were produced to address any areas identified as requiring improvement. We saw audits were carried out to ensure that the systems in place at the service were being followed and that people were receiving appropriate care and support. Audits included the environment, medication, fire safety, accidents and incidents, equipment and vehicle maintenance and recruitment. We saw that when audits identified any areas for improvement actions were usually taken to rectify the problem. For example, the staffing audit had identified four staff vacancies and we found the registered provider was working towards filling these. We noted that some work in relation to building maintenance had been requested in April and had still not been completed.

We saw that the registered manager completed a weekly service report, which was submitted to the head office. This included information about admissions, departures, staffing levels, accidents and incidents, complaints, safeguarding and premises. This enabled the operations manager to be kept informed about all developments and respond accordingly.

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 People who used the service were not protected against the risks associated with receiving care that deprived them of their liberty. Regulation 13 (5)(7)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. Regulation 17 (1)(2)(a)(b)