

S.E.L.F. (North East) Limited

# S E L F Limited - 15 Park View

## Inspection report

15 Park View  
Hetton-le-Hole  
Houghton Le Spring  
Tyne and Wear  
DH5 9JH

Tel: 01915208570






Date of inspection visit:  
08 February 2018

Date of publication:  
22 May 2018

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

The inspection took place on 8 February 2018 and was unannounced. This meant the provider and staff did not know we would be coming. The inspection was planned partly in response to concerns raised with the Care Quality Commission (CQC) about the management of a recent safeguarding concern.

We previously inspected SELF Limited - 15 Park View ('15 Park View') in September and October 2015, at which time the service was meeting all regulatory standards and rated good. The service was rated requires improvement at this inspection.

15 Park View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. 15 Park View provides care and support for up to eight people who have a learning disability. Nursing care is not provided. There were eight people using the service at the time of our inspection. The registered provider operates three separate services at Park View (numbers 14, 15 and 16). During this inspection we inspected all three services. Although the services are registered with the CQC individually we found that there were areas that were common to all three services. For example, training programme and delivery, joint staff meetings and one set of policies and procedures across all three services. For this reason some of the evidence we viewed was relevant to all three services.

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

The management of a recent safeguarding concern, which had the potential to impact on people who used the service and staff, was not robust in terms of establishing clear outcomes, nor was the investigation process sufficiently accountable.

Risk assessments did not always set out clearly enough how to protect people who may be at risk of absconding, and who presented particular risks to themselves

Medicines administration practices were safe and in line with good practice although staff did not always ensure confidential information was appropriately locked away, or that keys to the medicines storage units were securely stored.

Auditing processes had not identified some of the areas identified on inspection and the provider needed to review how they managed the auditing of the service in the longer term, both in terms of the efficiency of individual audits and who these responsibilities may in time be delegated to.

The majority of risk assessments were sufficiently detailed with clear strategies in place for staff to help

protect people in a way that also did not unnecessarily restrict them.

People who used the service interacted well with staff and told us they felt safe. No relatives or external professionals we spoke with raised concerns about safety.

There were sufficient numbers of staff on duty to meet people's needs and staff were aware of their safeguarding responsibilities.

All areas of the building were clean and processes were in place to reduce the risks of acquired infections. The registered manager agreed their response to a flood could have had more regard to people's individual hygiene. The premises were generally well maintained, with external servicing of equipment in place.

Pre-employment checks of staff were in place, including Disclosure and Barring Service checks, references and identity checks. These checks were refreshed after three years after external advice.

People had accessed external healthcare professionals such as GPs, dentists and nurses to get the support they needed. Staff liaised well with these professionals.

Staff received a range of mandatory training and training specific to people's needs.

People were encouraged to have healthy diets and were protected from the risk of malnutrition, with staff adhering to external advice from dietitians.

The premises were appropriate for people's needs and there were ample communal areas and bathing facilities.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Relatives and external professionals confirmed staff had formed good relationships with people, in part thanks to a continuity of care and a keyworker system.

People were encouraged to access their local community, which reduced the risk of social isolation.

The atmosphere at the home was communal and relaxed. Person-centred care plans were in place and regular house meetings took place. Care plans were reviewed regularly with people's involvement.

The service had good links with a local farm, stables and college, and people pursued a range of activities and hobbies meaningful to them.

People who used the service, relatives and professionals we spoke with gave positive feedback about the hands-on approach of the registered manager and the personal interest they took in ensuring people's day to day goals were met. The registered manager and staff had maintained a caring, person-centred culture within which people were supported to develop their independence.

We found the service was in breach of regulation 12 (Safe Care and Treatment) and regulation 17 (Good Governance).

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

A recent safeguarding concern had not been documented appropriately.

Staff did not always adhere to policies relating to the security and confidentiality of personal sensitive information.

People who used the service and relatives had confidence in the ability of staff to keep people safe and staff demonstrated a good knowledge of safeguarding principles.

Risk assessments were generally detailed and person-centred, although improvements were required regarding risk assessments relating to people who were deprived of their liberty for their own safety.

### Is the service effective?

**Good** ●

The service was effective.

Staff worked well with a range of healthcare professionals to ensure people's health and wellbeing was maintained and care planning was well informed.

Staff had recently received Mental Capacity Act 2005 training and Deprivation of Liberty Safeguards we saw were appropriate.

People enjoyed and were involved in preparing a range of meals. Staff acted on the advice of dietitians to ensure people's nutritional needs were met.

### Is the service caring?

**Good** ●

The service was caring.

The atmosphere was calm and relaxed, with positive relationships between peers and between staff and people who used the service.

Staff demonstrated caring and patient behaviours during the

inspection and relatives confirmed staff behaved in this way consistently.

Staff communicated well with people and had regard to their varying communication skills, preferences and levels of independence.

### Is the service responsive?

Good ●

The service was responsive.

Staff liaised proactively with external professionals when people's needs changed or when advice was needed.

People who used the service pursued a range of hobbies and activities meaningful to them and regularly accessed the local community.

Regular residents' meetings and a keyworker system meant people who used the service could raise queries or concerns via a range of means.

### Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Auditing was not always effective and did not always identify where service provision could be improved. Action plans were not always sufficiently detailed or measurable.

Accidents and incidents were responded to appropriately although were not recorded in such a way that allowed for a meaningful analysis of them.

Staff and people who used the service spoke positively about the registered manager and they demonstrated a passion for ensuring people received a good quality of care.

The registered manager and staff had successfully maintained a culture that focussed on people's potential to have better health and wellbeing outcomes.

# SELF Limited - 15 Park View

## **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.

We visited the service on 8 February 2018 and the inspection was unannounced. We do this to ensure the provider and staff do not know we are coming. The inspection team consisted of two Adult Social Care Inspectors 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 service.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

We also asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

During the inspection we spent time speaking with five people who used the service and observing interactions between staff and people who used the service. We spoke with seven members of staff: the registered manager, the director and four care staff. We spoke with one visiting healthcare professional. We attended a staff meeting. We looked at three people's care plans, risk assessments, medicines records, staff training and recruitment documentation, quality assurance systems, a selection of the home's policies and

procedures, meeting minutes and maintenance records.

Following the inspection we spoke with two relatives of people who used the service and three external professionals.

# Is the service safe?

## Our findings

The registered manager had not conducted an internal investigation, which had involved people who used the service, in a sufficiently robust manner. We saw they had interviewed all relevant members of staff and people who used the service but the investigation report was not clear about what the allegations were, what evidence was pertinent and proven, and what the outcomes were. The provider's safeguarding policy references the balance of probabilities (whether something is more likely than not to have happened) but the registered manager in this case did not make any findings in their investigation. This meant the investigation process was not accountable and open to scrutiny. It also meant the alleged incident and how it was managed could not be effectively used to learn lessons and improve how the service kept people safe in the future. The registered manager had initially acted on the basis of allegations being unproven, rather than acting on those allegations in a balanced way, prior to coming to any findings. Again, this was contrary to the provider's safeguarding policy.

We found a range of risk assessments in place, the majority of which were specific to people's individual needs and had regard to promoting people's individual freedoms. At times there was a failure to fully assess the risks posed by the freedoms enjoyed by people who were able to move between this service and the provider's other two services. Staff were not always aware of the whereabouts of people, who had previously presented a risk to themselves or others. On arrival at the inspection visit we were able to walk into the service without a staff member checking our identity. One person was at particular risk of harm by means of their own understanding of risk and road safety but there were no specific measures in place for staff to either monitor their whereabouts or reduce the risks they faced. The registered manager and provider agreed to address this specific area of risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

We noted occasions during the inspection where the office door was left unlocked, and the keys for the medicines storage cupboard were left in the office rather than kept with the person in charge of medicines. This meant there was the potential risk of medicines or people's confidential sensitive information, which was also kept in the office, being inappropriately accessed.

People's medicines otherwise were managed safely. People's medicine support needs were recorded in their care plans and medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. All medicine administration records (MARs) reviewed were fully complete with reasons for non-administration recorded where necessary.

When explaining the medicines administration process to us one senior support worker said, "There's always two staff, one senior and a support worker for all meds. I read out the medicines, [support worker] gives it to (the person) then I go back and sign the sheet (MAR)."



We observed staff providing people with their medicines. We noted medicines were administered in accordance with good practice and people were treated with respect and patience. People were approached in a gentle manner with medicines and spoken softly to by staff when being asked if they could take their medicines. They waited patiently while each person took their medicines before recording on the MAR. People appeared relaxed and at ease, engaging with the staff and happily taking their medicines. When one person was receiving their medicines they told us, "I'm gonna get me tablets" and people confirmed they received their medicines at regular intervals and were helped by staff to understand why they needed various medicines.

We found 15 Park View to be clean and well maintained throughout. Contracts were in place to ensure equipment was maintained and serviced to ensure safety. This included gas appliances, electrical installations and fire alarms and fire-fighting equipment. Portable Appliance Testing had been completed and the periodic electrical inspection was planned to be completed shortly after the inspection visit. The premises were clean throughout and people who used the service and visitors also confirmed this to be the case.

On the day of inspection the service did not have running water due to a flood. The registered manager told us this had occurred in the past two days and we noted it had been repaired by the end of the inspection. We asked the registered manager what contingency measures they had taken given the lack of running water and these amounted to filling containers with water so that toilets could be refilled and kitchen duties completed. There were no alternative hand washing means provided, such as alcohol rub or disinfectant wipes. The registered manager acknowledged they could have put in place more effective contingency measures.

Staff had completed specific training intended to better enable them to keep people who used the service and themselves safe, for example fire awareness training and safeguarding training. When we spoke with staff about how to identify signs of abuse and what to do if they had concerns, they were consistent in their responses and felt supported to raise concerns if they had them.

We observed people interacting in ways that demonstrated they were comfortable in their surroundings, with other people who used the service, and with staff. People told us for example, "I have all the staff around me and all of my friends around me, so I feel safe," and "I can play on the computer all night if I want – they don't restrict me. I am happy here." One relative told us, "They manage the problems well and make sure people are safe without going over the top."

External professionals we spoke with were generally positive about the levels of risk management strategies in place although some expressed concerns about the freedom with which people could access all three of the provider's services.

The registered manager had a proactive relationship with police liaison representatives. The registered manager met with the police every two weeks to try and manage or anticipate risks.

Recruitment processes continued to be followed for new staff to ensure suitable staff were employed. All necessary checks were carried out for each new member of staff including two references and disclosure and barring service checks (DBS) prior to someone being appointed. 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 minimise the risk of unsuitable people from working with children and vulnerable adults. The provider had recently introduced a three-yearly refresh of these checks, on the advice of the local authority, to help ensure staff who had been at the service a number of years

remained suitable to work in the service.

We found there were sufficient care staff on duty to keep people safe and meet their needs, day and night, and staff worked well as a team. Rotas demonstrated a consistent level of staffing and people who used the service and their relatives confirmed there was always sufficient staff available. Staff and relatives we spoke with also raised no concerns in this regard.

# Is the service effective?

## Our findings

Records showed that staff had completed a range of training in areas such as safeguarding, Mental Capacity Act (MCA), moving and handling, fire safety, first aid and food safety. Staff had also completed training specific to people's needs including epilepsy, diabetes and awareness regarding people with swallowing difficulties.

Staff received regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff received three supervisions a year and an annual appraisal. Records of these meetings showed they were used to discuss any particular support needs the member of staff had, as well as areas of practice such as behaviour management, medicines and infection control.

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

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.

We found the service was working within the requirements of MCA. Some people had DoLS authorisations in place which were contained in their files and included if any specific conditions were attached. People were supported to live their lives in a way that did not unnecessarily restrict their freedoms. For example, there were no keypad locks on doors and staff did work with people to help them understand that they shouldn't leave the home unaccompanied. People we spoke with said, for example, "I am not allowed out – I want to go out but I can't, it's not safe. I can go out with a member of staff." Whilst we found some specific risk assessments and strategies around this matter required improvement, staff focus on individual freedom was good. One person told us, for example, "I have got full independence. I can go for walks on my own if I take my mobile phone. If I have a problem I know and I can ring them and they will help me." Another said, "When you want to talk they are always there and they help you be the best you can be."

As discussed in the Safe key question, the registered manager informed us they would re-evaluate what was in place and make necessary changes to increase the safety and welfare of those in receipt of DoLS.

People continued to be supported to meet their nutritional needs. We observed a person preparing lunch for everyone with support from a member of staff. The person told us, "I'm making hot dogs and spaghetti and a cheese sandwich for someone because they didn't want hot dogs and spaghetti." While preparing food the staff member and person were chatting and joking.

We asked staff if people could have something else if they didn't want the two options of hot dogs and spaghetti or cheese sandwiches. The staff member said, "Yes, they can have corned beef or ham sandwiches or something else if they want."

We asked a member of staff if people received support during mealtimes. The staff member explained to us that everyone ate independently but that staff were always close by in the lounge area if anyone required support or needed gentle prompts to finish their meals. We then spent time in the lounge/dining area over the lunch period and observed people eating their meals independently. They enjoyed their meals and took empty plates back to the kitchen. We observed staff were on hand to support people when required. People told us, for example, "The food is good. All you have to do is ask if you don't fancy something and they'll do you something else," and "The food is nice. I do my turn in the kitchen but the staff do a lot of the cooking too."

People were supported to access external professionals to monitor and promote their health. People's care plans contained records of visits to and from GPs, dentists, opticians and other professionals involved in their care. We observed staff talking with one person who had approached them about pain in their ears. The staff member checked them over and said, "We'll have to get the doctor out to see you won't we?" Relatives we spoke with had confidence in the timeliness and appropriateness of staff seeking external help. This meant people had access to healthcare professionals when needed.

Staff meetings were held regularly and minutes of these meetings detailed a broad range of discussion points such as safeguarding, rota, professionalism, training and updates regarding individual's needs. We attended one team meeting and found staff demonstrated an ability to share important information appropriately.

# Is the service caring?

## Our findings

People who used the service told us, for example, "You are supported all the time. They are there for you when you want them. They are always having a laugh and a joke with you," and "They do care for me – they take me for meals and help me to everyday things." People were assigned a keyworker and we found these staff demonstrated a good knowledge of the person's individualities and preferences. Care plans contained good levels of information regarding people's preferences and wishes.

We found there to be a homely feel to the service where people interacted well with their peers and staff. We found this had a positive impact on people's wellbeing. One person told us, "It's fantastic. It's better than it was at other places I've been. You get freedom here. You can go in your bedroom and watch TV or you can go downstairs and be with everyone else." During our observations people interacted with each other well, for example playing board games and chatting with others and staff. One person took an interest in the baking another was doing and told us they were able to form good friendships at the service.

Relatives and external professionals we spoke with were all complimentary about the caring attitudes and behaviours demonstrated by staff. Relatives told us, for example, "Every one of them cares about what they do," and "The staff are really good and get to know people. They can cover any of the buildings but they all know what they're doing. [Person] gets on well with them all."

We observed staff treating people with respect and patience throughout the inspection, valuing their choices and the fact they may change their mind. Staff understood that people who used the service had differing levels of independence, and were mindful of this when asking people what they would like to do or encouraging them to take part in activities. Staff understood the sources of people's anxieties and things that may trigger negative behaviours, and demonstrated an ability to empathise and be patient with people. One person who used the service told us, "If you want to talk to staff they will listen to you all of the time. Sometimes when you don't talk and you bottle it up, it's not good. If I get stressed I just see one of the staff and tell them my problem." This willingness to have open conversations between staff and people who used the service was evident during the inspection, and had led to better outcomes for people's wellbeing.

We found the registered manager had acted as an advocate for people's rights and was passionate about them receiving positive outcomes, liaising with a range of health and social care professionals. When we spoke with these professionals they confirmed the staff and leadership focus at the service was to support people's independence as much as was practicable whilst also keeping people safe. Staff were therefore enabled to care for people in a way that was person rather than task focussed.

Relatives we spoke with confirmed staff facilitated visits from people who used the service, meaning people were able to maintain relationships that were important to them.

People who used the service told us they were involved in their own care planning and review, and that staff asked them regularly if they were meeting their needs. Regular service user meetings were held as a means of ensuring people had a forum in which they could raise concerns or queries. Relatives confirmed they were

also involved in care planning and review.

Care plans contained detailed information about how best to communicate with people on their terms and how to ensure staff did not trigger or raise anxieties in people. For example, giving people specific activities as an alternative if they were distressed. When we spoke with staff they displayed a good knowledge of how to communicate with people and we observed numerous examples of this during the inspection.

People's rooms we saw were well decorated and personalised, for example with pictures, memorabilia and their own belongings.

# Is the service responsive?

## Our findings

Before people started using the service assessments of the support people needed were carried out, covering mental capacity, mental health, eating and drinking, mobility and communication. As well as people's physical needs these assessments also covered people's religious, cultural and spiritual needs. The registered manager told us, "We do an assessment before anyone moves in. Then the previous provider come and do a workshop with us."

People had a range of care plans in place to meet their needs identified from their assessments. Care plans were personalised and included peoples' choices, preferences, likes and dislikes. Care plans were detailed and contained clear directions to inform staff how to meet the specific needs of each individual.

Records showed care plans were reviewed on a regular basis and in accordance with people's changing needs. All care plans we reviewed were up to date and reflected the needs of each individual person.

People had behaviour profiles which included information about types of behaviours people had presented previously, identified triggers, indicators and contributing factors that may increase the likelihood of the person displaying those types of behaviours. Profiles also detailed potential actions that should be taken by staff in the event of people displaying such behaviours or prior indicators. For example, avoidance or distraction from particular activities. There was also details of physical intervention and picture guidance to demonstrate appropriate physical intervention that could be used as a last resort.

The service was responsive to people's individual needs. We reviewed one person's self-development care plan. It related to the application of make-up as it had been identified in the person's assessment that wearing make-up raised their self-esteem. The development plan was broken down into tasks and progress was recorded monthly on how independently the person was able to complete each task. From this monthly assessment it was clear the person had become more confident and improved in their ability to apply their own make-up. This meant people were assisted to achieve goals meaningful to them in a planned way.

Another person told us, "We do money management, arts and crafts. I go to the college and the farm – I do animal care and will get a certificate in 17 weeks when I finish." Another said, "I go to college and I do hair and beauty on Mondays and Tuesdays." Again, this helped demonstrate how the service helped people pursue their own interests and support them to learn new skills.

People had activity timetables in their care files which included details of what activities people would complete each day. These varied from practical/self-development tasks such as self-care, laundry and food preparation to hobbies and interests such as swimming, cross stitch, cookery and local walks. One person told us, "We go on trips to Lightwater Valley and Beamish museum. We learn about animals and I went to Durham to buy computer games." Another said, "We went to Chester and stayed over, then went to Chester Zoo."

The approach to activities and care planning more generally was person-centred and had a regard to

people's choices. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care.

At the time of our inspection no one at the service was receiving end of life care. Care records showed that initial discussions had taken place with people and they did not want to have discussions around end of life care at that time.

We saw evidence that the registered manager and staff liaised promptly and regularly with external professionals when people's needs changed, or when further support or advice may be needed. We spoke with some of these professionals who agreed staff members kept them updated and appropriately raised questions or concerns with them in a timely manner.

With regard to complaints, there had been none recently and no one we spoke with raised concerns. People who used the service and relatives confirmed they knew how to raise any concerns they may have, and who to raise these with.

Residents' meetings took place regularly, at which people who used the service could discuss the planning of future activities, menu options, and any concerns they may have. People we spoke with were also confident they could raise any concerns with their keyworker. One person told us, "We have service user meetings where we plan outings on the bus and other things." People confirmed they were involved in the review of their own individual care but also decisions relating to the service more generally.



## Is the service well-led?

### Our findings

Auditing processes required improvement. Some areas of risk and poor practice had not been identified by the auditing processes in place, for instance the areas of improvement required in the handling of confidential information and the lack of clear practices in place to manage specific risks to a person who was at risk due to a lack of road safety awareness. The registered manager had been made aware of concerns, following a visit by the local authority, about confidential information potentially being inappropriately accessed should the office door not be locked when not staffed. We found no meaningful changes had been made since this external advice and the same risk remained at the time of our inspection.

Auditing processes were completed by the registered manager, who also conducted the majority of audits for the adjacent service they were also the registered manager for, as well as some of the auditing for the provider's other service, located across the car park. The audits were monthly and included health and safety, maintenance, medications and control of substances hazardous to health. We found, whilst they had maintained a level of oversight across all three services, this was not a practical or manageable means of ensuring service provision was maintained to a high standard in the longer term. Both the registered manager and director told us some of the registered manager's duties would be appropriately delegated when new 'Head of Care' positions were filled. The provider's intention was to have a Head of Care at each of the three locations to ensure there was sufficient leadership and managerial support. At the time of inspection two of the three planned posts had been filled, although the staff had yet to begin work.

In addition to onsite auditing there was a regular visit by another company director, who undertook a range of checks. These included health and safety checks such as whether fire routes were clear, infection control standards, maintenance issues and water temperatures. They also reviewed care plans and staff files to see if there were any concerns or patterns evident. With regard to medications, this audit, completed in January, did have a section entitled 'medication file/stock' with a 'yes' box ticked. It was unclear what information this audit had reviewed in terms of medications.

We also found accidents were recorded individually but they were not stored centrally by the registered manager. There was an accident book, but this had not always been completed. This meant the means of identifying patterns of accidents and incidents was more difficult and that information was not always accurate and up to date.

Opportunities to improve and learn from previous identified practice shortfalls had not yet been taken, and advice had not been acted on in a timely fashion.

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

We reviewed the service's overarching 'Mission Plan/Action Plan' for 2018 and found it to be lacking in detail and dates for individual actions, against which to monitor progress. Whilst the general goals in the plan were positive, it was not a plan against which performance could be effectively measured at the end of the year.

People who used the service interacted well with the registered manager, who demonstrated an excellent knowledge of the needs of people who used the service. One professional told us, "They are proactive and work with us well. They do offer people and staff encouragement and support."

The majority of records we reviewed were accurate, up to date and person-centred. The registered manager had been in post for a number of years and had relevant experience. Staff we spoke with gave consistently positive feedback about the registered manager's hands-on approach to the service and the support they gave staff in fulfilling their roles. One staff member told us, "We can talk about anything at the team meetings and they always listen if we have a problem. They'll drop things and help you sort it out," whilst one relative said, "They have been like part of the family."

Staff meetings were held regularly as a means of ensuring information was shared and there were additional forums in which to raise any queries. We found evidence that the registered manager actively made themselves accountable to staff and was open with external agencies when it was appropriate to share information externally. The registered manager and director displayed a lack of knowledge in some aspects of when they would need to notify CQC of relevant events and agreed to review relevant guidance on this matter to ensure they notified CQC of appropriate events.

Good community links were in place, particularly with a local college, stables and farm and football club, all of which enabled people to engage in a range of activities meaningful to them. The registered manager had ensured people were able to access their community in a positive, meaningful way, and that they were protected against the risks of social isolation.

Turnover of staff was relatively low and staff morale was good, both with new staff and more experienced members of the team. We found staff had helped to deliver the person-centred service the leadership aspired to provide, with a focus on helping people achieve levels of independence within a homely and supportive environment. The openness and communal nature of the culture and atmosphere was a positive factor in the feedback we received, but the registered manager and provider needed to ensure the risks associated with such openness, for example people being able to move between all three locations, given the particular risks people who used the service faced, were more closely managed.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider did not have sufficiently detailed risks assessments in place for people whose liberty was restricted for their own protection. Safeguarding investigation policies had not been appropriately followed.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Auditing processes had not ensured poor practice was improved and lessons learned.</p>