Autism Care UK (3) Limited

Alexandra Park

Inspection report

Alexandra Way
Newbiggin by the Sea
Northumberland
NE64 6JG
Tel:01670812615
Website: www.autismcareuk.com/

Date of inspection visit: 27 August and 1 and 4 September 2015.
Date of publication: 09/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 27 August and was unannounced. Further visits to the site took place on 1 and 4 September 2015 and were announced. This was the first inspection of the service under the current provider.

Alexandra Park is registered to provide accommodation for up to 32 adults and children with learning difficulties and mental health issues. It comprises 28 single occupancy bungalows and a four bedroomed house, located within extensive grounds. Support is provided over a 24 hour period by staff who are based in individual bungalows and managed from the on-site resource centre. The resource centre is also used for training, social activities and administration of the site.

The home had a registered manager who had been registered with the Care Quality Commission since February 2015. A registered manager is a person who has registered with the Commission to manage the service.

Summary of findings

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.

Staff were aware of safeguarding issues, had undertaken training in this area, including safeguarding children training, and told us they would report any concerns about potential abuse. Records showed staff were able to raise concerns and these were addressed by management. We found some minor issues in relation to the management of medicines. Some medicine records were not complete, "as required" medicines did not always have plans in place on how they should be used and there was some over stocking of medicines because effective checking systems were not in place.

People and staff told us there had been a high turnover of staff in recent months and this had caused some people to feel unsettled. The registered manager told us all shifts had been covered, although a number of staff were undertaking additional shifts at the current time. Proper recruitment procedures and checks were in place to ensure staff employed at the home had the relevant skills and experience to support people. The registered manager told us there was a need to balance new staff coming into the service with more experienced staff, to maintain the quality and continuity of care. Staff told us they had access to a range of training. Training records indicated a wide variety of training was offered and checks were made to regularly update staff skills.

People told us they were encouraged and supported to go shopping and cook their own food. They told us they could make their own choices about what they ate, although staff encouraged them to eat healthily.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The registered manager confirmed appropriate assessments and applications had been made, where people met the criteria laid down in the DoLS guidance. Staff did not always understand the concept of best interest decisions and one staff member suggested that where a person was unable to make a decision for themselves they would contact a person's care manager for advice. Capacity assessments were not always used appropriately and it was not clear how or why best interests decisions had been taken.

People and relatives told us they were happy with the care provided. We observed staff interacted well with people and supported them appropriately. They supported people to make choices and understood about their personal and particular needs. People had access to health care clinicians such as doctors, nurses and mental health professionals, to help maintain their wellbeing. People were treated with dignity and respect and staff appreciated people's need for privacy at times.

People had individualised care plans that were thorough, addressed their identified needs and provided good detail for care staff to follow. Some care plans were not individualised and did not reflect the personal needs of people. All people had care plans for sun care and swine flu, without any particular identified risks. Reviews of care plans were not always detailed and some consisted of a simple date and signature. The support manager demonstrated a new review system they were looking to introduce. Activities were based around people's individual needs, such as trips out, swimming and meals at local cafes and pubs. People also told us they could socialise with their friends and often had friends round to their bungalow in the evening. One person told us he thought there should be more organised activities. There had been nine formal complaints in 2015. There was evidence that complaints had been responded to, although where investigations were on going is was not always possible to ascertain the outcome. People living at the home were able to raise concerns with the registered manager and these were addressed.

Regular checks and audits were carried out at the home. These were based around individuals and their needs. New audits had recently been introduced by the provider but an action plan had not been developed at the time. Existing audits process had not identified some of the issues we noted around medicines and the use of the MCA. Staff were positive about the leadership of the home and felt better supported by management over recent months. They felt they were able to raise issues with the management, if they had concerns.

Summary of findings

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 

Not all aspects of the service were safe.

We found some minor issue with medicines. Instructions for the application of creams and lotions and the use of "as required" medicines were not always clear. Some people told us changes in staffing could cause upset and meant that care was not always consistent.

People told us they felt safe at living at the service. Risk assessments had been undertaken in relation to people's individual needs and the wider environment.

Safeguarding issues were recorded and dealt with appropriately. Staff had received training in relation to safeguarding. Proper recruitment processes were in place to ensure staff who worked at the home had appropriate skills.

Is the service effective?

Good 

The service was effective.

Staff told us and records confirmed a range of training had been provided and regular supervision and annual appraisals took place.

The registered manager confirmed appropriate processes had been followed in relation to Deprivation of Liberty Safeguards applications, under the provision of the Mental Capacity Act (2005). Staff did not always understand the concept of mental capacity assessments and the process for best interests decisions.

People told us they had access to a range of meals and drinks and many went shopping to make food purchases themselves. Individual bungalows were decorated to people's personal choice. Safety aspects, such as hidden heaters had been installed in some areas.

Is the service caring?

Good 

The service was caring.

People told us they were happy with the care they received. Staff supported people in their individual activities and pursuits. Relationships between staff and people living at the service were positive.

Advice and support was sought from a range of professionals to help maintain and improve people's wellbeing. No one was currently accessing advocacy services. Staff told us the majority of people had regular contact with their families for support.

Staff understood about the need to maintain and protect people's privacy and put this into practice. People were supported to develop skills to retain their independence.

Summary of findings

Is the service responsive?

Good

The service was responsive.

Care plans were predominately individualised and contained good detail of how people should be supported. Some care plans were included in all people's records and did not always reflect people's individual needs; such as a plan for dealing with swine flu. Reviews of care plans were not always detailed. New care record documentation was being introduced.

Activities were predominately based around individual needs, such as swimming, trips out and meals out. People indicated they could make choices about activities. Communal activities were limited, although some did take place, such as pizza nights.

Complaints were recorded and dealt with. Concerns raised by people were noted and action taken to address them.

Is the service well-led?

Requires improvement

Not all aspects of the service were well led.

A range of checks and audits were undertaken to ensure people's care and the environment of the home were effectively monitored. However, it was not always possible to ascertain if action points raised from these audits completed. new provider audits had been introduced but existing audits had not identified some of the issues around medicines..

Staff talked positively about the support they received from the registered manager and said things had improved at the home in recent months. Some staff said it would be helpful to have additional management time to oversee work at the service.

Staff meetings and meetings with people who lived in the service took place. People told us managers listen to their suggestions and acted upon them.

Alexandra Park

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 August and was unannounced. Further announced visits were undertaken on 1 and 4 September 2015.

The inspection team consisted of two inspectors.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority safeguarding adults team and the local Clinical Commissioning Group. We used their comments to help plan the inspection.

Not everyone who used the service was able to speak with us. We spoke directly with four people who used the service to obtain their views on the care and support they received. We spoke with the registered manager, a support manager and five support workers. Additionally, we spoke with two relatives of people who used the service and a health worker, who were visiting the service during the inspection. Following the inspection, we spoke with two care managers from the local NHS Trust who were involved in the care of people living in the service.

We were shown round some people's bungalows, with their permission, and were able to review their accommodation arrangements, including kitchens, bathrooms and living areas. We also looked at facilities in the communal areas of the service. We reviewed a range of documents and records including; four care records for people who used the service, six medicine administration records, seven records of staff employed at the home, complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings with people who used the service and a range of other quality audits and management records.

Requires improvement

Is the service safe?

Our findings

We looked at how medicines were managed at Alexandra Park. Each bungalow managed the person's medicines on an individual basis. There was an individual medicine administration record (MAR) and a locked cabinet for each person on the site. All medicines were stored safely and locked away. The support manager told us no one on the site was currently prescribed controlled medicines. Controlled medicines are medicines where there are legal requirements about how they are stored, used and checked.

We found some minor issues around the recording and management of medicines. Some topical creams and specialist shampoos had not always been signed for. Topical creams often had instructions such as "apply as directed" or "apply to affected area." However, there were no instructions as to what area they should be used on or no diagram indicating the areas the creams should be applied to. Some creams and ear drops had not been dated when they were opened to ensure they were not used beyond the recommended expiry date. For another person a cream had originally been prescribed to be used on a regular basis, but staff told us this was now to be used only when necessary. The MAR did not reflect this change.

A number of people were prescribed "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. Not everyone who was prescribed these types of medicines had a care plan detailing when it should be given, how much should be given and what other actions staff may take. We also noted there was some overstocking of medicines because effective monitoring of stocks had not taken place. For example, one person who was prescribed paracetamol for pain relief on an "as required" basis had 200 tablets stored in their cabinet.

In many cases when a tablet was administered there were the signatures of two staff to confirm that it had been given and taken correctly. Hand written MAR had two signatures to say they had been transcribed fully and properly. Two entries had not been signed in this way. Staff confirmed that only staff who had received training or team leaders were able to administer medicines. Records confirmed staff had undertaken appropriate training.

People we spoke with told us there were enough staff to support them. Some people said it was necessary for other staff to help them, if care workers were away or off sick. We noted there were various lists pinned around the main administrative building, asking staff to volunteer for additional shifts. Staff told us they did work additional shifts and could often be contacted at short notice. They said that recently turnover at the service had been high and they felt under pressure at times to cover sickness. One person told us, "There has been a bit of turnover of staff. I think it can be a problem for other residents who don't like new faces." A relative told us, "Staff do get moved about, just as people get settled with them. They get moved about and this can make people feel lost." The support manager told us, "Staffing levels are okay. We never go below what each person is assessed for in terms of support. If you're short staffed because someone has gone sick a manager always steps in. They're very responsive like that." The registered manager told us that managing the diverse nature of the service, with individual bungalows and individual staffing rotas did sometime pose challenges to the service. He told us staff turnover had slowed in recent months and the staff cohort was beginning to stabilise.

We asked people if they felt safe living at Alexandra Park. Most people told us they did feel safe. One person said, "The staff are nice. Yes I feel safe living here." A relative told us, "I feel he is safe here and quite secure."

People told us they had received training in relation to safeguarding adults and would report any concerns to the registered manager or team leader. Contact details for the local authority safeguarding adults team were widely available around the complex. We saw from records that where staff identified any issues that might be considered a safeguarding matter, these had been reported and recorded. The registered manager logged any safeguarding issues. The records showed the circumstances of the concern and the action taken, including, if necessary, interviewing staff or others about the issue to determine the situation. A note was also made of contact with the local safeguarding adults team.

Staff were also aware they could raise other issues with team leaders or managers. We saw some staff had spoken to managers about issues which concerned them, such as staff being late or the welfare of people living at the

Is the service safe?

complex. We saw details of the concerns were logged or staff were asked to complete statements about their concerns. These were then investigated and, if necessary, formal action was taken.

Risks were considered in relation to each individual person and we saw care plans contained a range of risk assessments related to various activities and people's specific health conditions, such as falls or epileptic fits. One person liked to ride a bike and an assessment of the risk associated with this, for this individual, was evident in their care records. Where risks related to people's individual behaviour then clear guidance for how staff should react were detailed with the assessments. Wider risk assessments were also in place for the operation of the service, such as fire risks and the Control of Substances Hazardous to Health (COSHH).

The registered manager showed us records that confirmed accidents and incidents at the complex were recorded and investigated, if necessary. Records detailed the nature of the accident or incident, the action taken at the time, any injuries or other issues. In some instances it was noted that follow up action had been taken, such a referral for further assessment or support from other health agencies. However, it some cases it was not always possible to determine what the outcome of the review was. The support manager told us that where the incident involved any type of restraint or containment then more detailed forms were completed and reviews were undertaken. Records showed a fuller review these incidents had been undertaken.

Staff personal files indicated an appropriate recruitment procedure had been followed. We saw evidence of an application being made, references taken up, one of which was from the previous employer, and Disclosure and Barring Service (DBS) checks being made. Some files for staff recruited in the past did not always contain evidence of references, although checklists stated they had been requested. Staff confirmed they had been subject to a proper application and interview process before starting work at the service. The registered manager told us recruitment was an ongoing issue. He said it was important to ensure there was a balanced recruitment process, engaging experienced staff alongside staff who were enthusiastic but with limited recent care experience. A support manager demonstrated that, where necessary, the provider's disciplinary procedures were followed to investigate and deal with any issues or concerns.

The support manager told us the cleaning of each bungalow was carried out by the person living there or by care staff who supported people. Bungalows that we inspected were generally clean and tidy. Each bungalow had a cleaning checklist of tasks that needed to be completed to maintain the cleanliness of the home. Staff had access to personal protective equipment (PPE) such as gloves. People had personal toiletries in their bathrooms, although there was also liquid soap for staff to use. The importance of hand washing before food preparation was also underlined for staff and the people they were supporting.

Good

Is the service effective?

Our findings

The registered manager confirmed that where people had been assessed as potentially meeting the criteria for Deprivation of Liberty Safeguards (DoLS) as defined by the Mental Capacity Act (2005) (MCA) then applications had been made to the appropriate safeguarding adults team.

We spent time speaking with staff about obtaining consent from the people they provided care for. They said that in cases where a person lacked capacity to consent to care, or where a person needed an intervention to prevent harming themselves, they were guided by the best interests assessment information in each person's care plan. Some staff did not have a clear understanding of mental capacity and consent. For instance, one support worker said that if they could not obtain consent from a person verbally, they would contact the care manager for advice. We found the use of mental capacity assessments and best interests decisions was at times extended to day to day care decisions. Capacity assessments were in place for each care plan in people's records, detailing personal care needs and food preferences, rather than for significant care decisions. Despite capacity assessments being in place, there was limited evidence to show appropriate best interests decisions had been made, considering the least intrusive approach to care. Information was often limited to statements such as, "X's care manager and family agree with the care plan for…" From looking at the records of people we saw managers had followed legislation in their provision of care to people with a Court of Protection order in place.

Relatives we spoke with told us they felt staff had the right skills to support people living at the home. One relative told us how staff had learnt to communicate in a particular way to support the person they were caring for.

The provider used a training matrix to track the training of all staff at the service. This included mandatory training, as well as specialised training that was given to staff based on the needs of people using the service. Managers were able to plan training in advance to make sure staff remained up to date. Staff had received training in safeguarding adults and children, first aid, fire safety, moving and handling, infection control and food hygiene as mandatory. Professionals within the organisation delivered specialist training on medication administration, person-centred planning, Makaton communication and the TEACHH approach to supporting people with autism. This meant staff were able to deliver highly specialised and individualised support to people using evidence-based practice.

Staff were required to complete all of their mandatory training and a one-week pre-appointment course before they were able to work with people unsupervised. This time was used to assess the suitability and competence of staff and to ensure their skills were matched to the needs of the people they would be providing support to. Staff were also required to successfully complete the accredited Non-Abusive Psychological and Physical Intervention (NAPPI) training prior to starting work. This meant staff were equipped to support people with complex needs. Staff were encouraged to undertake an NVQ in social care up to level three, unless they already held a relevant qualification. 69% of staff in a care role had achieved at least a level two NVQ or were currently studying towards level three.

Staff had received an induction that was structured around the needs of the people who lived there. For instance, staff were given an induction pack that included key competencies for them to demonstrate during a timeframe set by their mentor. The induction pack included learning for staff that was based on evidence-based care from key industry organisations and followed the Skills for Care Common Induction Standards 2010.

Staff told us the induction process was thorough and helped prepare them for the role. A team leader said, "Part of the induction includes three observations from a manager, which have to be good before you can work without supervision. They really pay attention to detail during this. The NAPPI training is excellent and we have to prove ourselves in this before we work unsupervised. They also check things like hand washing technique to make sure we understand infection control and we have to talk through lots of different scenarios to discuss how we'd handle them." A senior trainer reviewed induction progress and ensured staff had achieved a minimum standard of skill and competence.

One team staff member thought training could be improved in some areas. They said, "The report writing and autism training could be more specialised and the restraint training isn't always enough. We're taught to use three different restraint techniques but sometimes none of them are suitable if the person is particularly violent." Although

Good

Is the service effective?

the standard of training information and trainer feedback was very good in most cases, we found an infection control workbook that did not clearly demonstrate staff competence or understanding. Despite this, a trainer had signed the member of staff as competent in this area.

A probation review form was used monthly for the first six months of employment for support workers and team leaders, to track staff progress and ensure they were fit to work in the best interests of people. Although we found evidence managers were proactive in extending probationary periods and offering additional training, feedback was not always supportive. For instance, under 'General progress' for one person, a manager had written only 'Slow.'

Each member of staff received supervision every six to eight weeks and an annual appraisal. A 'job chat form' had also been introduced to provide feedback, offer praise or to monitor performance or conduct issues with staff. We found this approach had been used on an ad-hoc basis to quickly record a meeting with a member of staff, such as on their return to work after a period of sickness. Formal supervisions included a structured agenda and notes were detailed and tracked so that actions taken after the meeting could be recorded. Staff were encouraged to reflect during supervisions and we saw that positive, encouraging feedback was regularly given by managers. For instance, one person's feedback read, "Well done and thank you for all of your support in a very challenging team." Annual appraisals were detailed and included an action plan with a time scale for staff to demonstrate their progress. One member of staff we spoke with raised a concern about the confidentiality of supervisions. They said, "Supervisions are good and we can talk about any problems and ask for special training. I do worry though that they're not confidential."

Where restraint was necessary, this was used only in circumstances where a robust and rapid assessment had taken place. A team leader said, "We use three re-focusing techniques initially with someone whose behaviour is deteriorating or becoming aggressive. If that doesn't work, we have to make a dual decision with a colleague to use a restraint technique and only when we feel that the person's behaviour is dangerous." We spent time speaking with a support manager about this. They told us that if any of the restraint techniques taught in the NAPPI training were used, a NAPPI incident form was completed alongside an ABC behaviour monitoring form. The documentation was used to track the behaviour of people and was used with a multidisciplinary care team to identify trends and risk factors that contributed to complex behaviour. Staff were offered a debrief immediately after an incident and we were told there was a new approach to involving the individual, if this was appropriate. For example, a person who had reacted with member of staff was invited to their own debrief, as part of a post-incident support process, to help them understand the impact of their actions.

Staff told us they worked with people to create their own menus that included food people liked and met their dietary needs. For instance, diets that were low in fat or high in fibre could be given that also included people's favourite things to eat and drink, because staff were aware of the needs of the people they cared for. We looked at the menus on display in three bungalows. We found them to be varied and in some cases to have been created by people themselves. People we spoke with told us staff supported them to go out shopping and to make their own meals. We also noted from records people went out for lunches at local pubs or restaurants, or occasionally had takeaway nights. Staff also maintained a food tracking system that included a stock check of items in chilled or frozen storage with their open and expiry dates clearly on display for other staff. This meant that people were protected from the risks associated with improperly stored or expired food.

People resided in individual bungalows located on the wider Alexandra Park complex. Bungalows were adapted to meet people's individual needs, as far as possible. For some people showers had been fitted as an alternative to baths. Where people required sleep in support overnight then conservatories had been built onto the bungalows to allow staff to stay at the home without intruding on people's own space. Some bungalows were being adapted because of people's particular behavioural needs. For example, some bungalows had heaters in the ceiling so as to protect people from the risks of burning themselves and some bungalows had reinforced walls and tamper-proof showerheads to protect people from hurting themselves. Access to the complex was through the main hub building. The main hall in this area was used for day services and for staff training. Access to the rest of the building and the wider complex required crossing the hall, intruding on people's activities or ongoing training.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received. One person told us, "I like living here. The staff are nice. I have two or three who support me. I can get a bit of support when I need it." A relative told us, "Staff are very nice. They are fully aware of his likes and dislikes." Another relative told us "It's been much better that I thought it would be. The first six weeks were fantastic. The staff know how to read his "signs." I couldn't ask for better."

We observed how people and staff interacted during the times we visited their bungalows. Relationships appeared to be friendly and relaxed. Staff were supportive and encouraging of people and helped them tell us what they had been doing or what their plans were. Staff talked about how the bungalows were people's homes and how they tried to support them but maintain their independence. One person told us, "The staff help me but I also get a bit of independence in that way." A relative told us, "Staff know how to approach (relative). They have increased his sense of independence, with someone there to depend on. He is very proud he has a bungalow to call his own." A health professional, visiting to review a person's care, told us, "The staff seem to have built up a good relationship with X." A care manager told us, "Staff have a good relationship and understanding of X. He has made good progress."

Staff told us no one had any particular cultural or religious requirements. Some people communicated using signs and gestures. Staff supporting these people had learned their particular signs or gestures, so they were able to communicate with them. This meant that even though they used alternative methods of communication people were able to express their needs.

Staff told us they involved people in their care as much as they could. People were encouraged to clean and maintain their bungalows and personalise the environment. One care worker told us how she sat down with a person she cared for to explain about a dentist's appointment. She told us, "If you talk her through things she is better and does understand." Staff also told us people were encouraged to make choices for trips out. Where people could not be actively involved in their care planning we saw care managers and family members had been consulted to ascertain what people liked or disliked and what their preferences might be in certain situations. One relative told us, "Usually there is a meeting if there is a concern. He has massively improved since he came here. He is now how he was ten years ago."

Relatives told us they were kept up to date with information about their relative's care. One relative told us, "They are very, very open; that's what I like about them. They say what they mean. You get a complete open picture. There are books and a diary we can read." Another relative told us, "We have had the odd meeting here, but more often than not they will take place at home; which is good." A care worker told us how care staff rang a person's relative every evening to update them on the person's care and tell them what they had done that day. We saw in some people's bungalows pictures were used to show people what was happening or activities they were going to do. A professional, who was visiting the site on the day of the inspection, told us he had found communication from staff to be good.

People's health and well-being was supported. We saw copies of letters from health professionals indicating people had attended hospital or other appointments. From looking at the healthcare files we found people were supported to receive timely and expert healthcare support, because staff were efficient and proactive when involving a team of multidisciplinary professionals. For instance, staff had observed a change in the gait of a person and had sought the advice of a physiotherapist and had arranged an orthotics appointment. Professionals involved in safeguarding had been involved appropriately after an incident with a person. There was a consistent track record of the involvement of psychologists as part of plans to maintain people's wellbeing and avoid aggressive or violent behaviour.

The registered manager told us no one at the home was currently being supported by an advocate. He said one person had previously accessed an advocacy service and they were looking to possibly reinstate this, but nothing had yet been formally arranged. He told us around 80% of people living at the home had regular contact with their families, or there was a family member who could be contacted to discuss care matters. He said families were generally proactive in supporting people in expressing their views.

Staff were aware of the need to respect people's privacy and dignity. People were always asked permission for

Good

Is the service caring?

inspectors to come into their homes and staff advised us when it was not appropriate to visit. During visits to some bungalows people went into their bedrooms and closed the door, even though they had agreed to us visiting them. Staff respected this, but did knock on the door and enquire if the person was alright. During the evening and night time staff used facilities in conservatory areas to maintain observation of the person, whilst respecting the right to privacy in the home. Care plans detailed how people should be supported when they went swimming to ensure they were safe, but also had their dignity maintained.

Good

Is the service responsive?

Our findings

Relatives told us they thought the service was responsive to people's needs. One relative told us, "Issues are always looked at. There is nothing that hasn't been sorted. They've often done things before we have even asked."

The registered manager told us the service tried to ensure care was always person centred and that individual needs were reflected in their plans and the care delivered.

People had individual care plans that addressed their needs, including their physical health and wellbeing and their psychological health. Care plans were detailed and had a good range of information regarding individual's needs. For example, one person, who was supported with their personal care, had detailed instructions for staff, including giving them 15 minutes to "come round" in the morning and that they preferred their hair to be dried with a hair drier. Another care plan identified a person sometimes was tempted to eat inappropriate items. The care plan detailed how staff should address this, including the provision of simple sweets to distract the person.

Some information in care plans was repetitive and some care plans were universally in all people's care records, irrespective of individual needs. For example, all people had care plans for sun care and the risk of swine flu, despite no clear identification of a risk or that these risks were greater than the general population. These care plans were not personalised and contained over simplified actions such as, "Check weather forecast." The support manager told us the inclusion of some care records were advised from the provider organisation.

Care plans were reviewed monthly, although we found one record which had not been reviewed since April 2015. The support manager told us they she was aware of this and action was being taken to bring the care record up to date. Some care reviews consisted of a date and a signature. It was not possible to identify how the care plan had been reviewed and whether any changes had been made to plan. The support manager told us care plans were linked to 12 week development plans. However, these were often limited to a number of key points. Whilst some development plans identified where outcomes had been achieved, we found others where the same outcomes were repeated. Care plans were also monitored using people's daily diary sheets, so it was not always possible to see from development plans alone to see how far people had progressed. The support manager showed us that care planning documentation was being reviewed, including an improved system for reviews and recording changes.

People and staff told us activities were individualised to meet people's identified needs. We saw people went out shopping, on visits to local pubs or cafes, swimming, walks, local places of interest and other locations. One staff member told us how a person enjoyed going to the cinema and musical theatre. The person showed us posters of productions they had seen. They also told us they enjoyed attending a weekly disco in a nearby town. Another person spoke with us about how he enjoyed working on his allotment and showed us some of the produce that he had grown. He told us he had recently built a small greenhouse in his garden and was growing tomatoes. The person also had two pet rabbits. Another person told us how he liked to bake and regularly made biscuits and cakes. He said he sometimes had friends round to his bungalow in the evening, when they would sit and chat. They would sometimes have a drink and a pizza. The support manager told us how one person had not been able to go out when the initially started living at the service. She said this person was now going out regularly for meals and other activities.

People told us they had regular contact with their relatives. We saw some people went to stay with relatives overnight or at weekends, as part of their regular routine. Other people's relatives regularly visited people in their own bungalows. People were also supported to maintain contact with the community where their family resided, such as attending local hairdressers to have their hair cut and shopping in the local area.

The registered manager said some joint activities took place on the site, utilising the large hall in the main hub building. He said there were sometimes pizza nights held there or occasionally birthday parties, but these were not regular events as most people were engaged in their own activities or preferred to stay in their bungalows at night. One person told us he would like to see more group activities, where people on the site had opportunity to socialise. He felt perhaps there could be events such a quiz nights, although recognised that people living at the complex had different abilities.

People who we spoke with told us they were able to make choices. They told us they could go out to places they wished to visit, or visit friends around the complex. They

Good

Is the service responsive?

said they were able to purchase items they liked when they went shopping. Most people had decorated their bungalows in a style that suited them and some people had installed additional services such as satellite television. During our inspection we observed people being offered a choice of snacks, asked what television programme or video they wished to watch and being asked what they would like to do during the afternoon. We witnessed one conversation where a person was planning an outside activity. Staff asked the person which staff she felt she got on best with and who she would like to accompany her on the activity. Staff reassured the person that they could make a free choice and other staff would not be upset.

The provider had in place a complaints policy and copies of the policy were displayed around the complex or available in individual bungalows. People we spoke with told us they knew how to make a complaint and felt any issues they raised were dealt with. One person told us, "I'd see (registered manager). I just pop into his office. If I had something I wanted to raise." Relatives told us, "We can raise issues and concerns; no problem. If there is an issue it is usually sorted out" and "Any issues are always looked at. There is nothing that hasn't been sorted out." Records indicated there had been nine formal complaints since the start of 2015 and detailed the nature of the complaint and some of the action taken; such an investigation or conversations with staff members. We saw for one matter a formal letter had been sent to the person complaining and a further phone call had taken place to clarify issues. In some cases it was not always possible to see the outcome of the investigation. For example, in one instance the outcome was identified as "meeting arranged", but with no clear outcome from the meeting or whether it had occurred.

The service had received four formally recorded compliments during 2015. One care manager had fed back to the service that a family had been "over the moon" with the care their relative had received.

Relatives we spoke with told us the service had been supportive and proactive when people moved into the service. One told us how staff had visited and worked with a person on a daily basis, prior to them moving into the service. They said, "It went much better than I thought it would be. The first six weeks were fantastic. I couldn't have asked for better."

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since February 2015. The registered manager and one of the service support managers assisted us during the inspection.

Quality checks at the service were predominantly carried out by looking at the overall care of individuals using the service. A quality assurance assessment (QAA) was undertaken and checks made on the overall service provision along with particular checks on the person's accommodation and their individual care and care plans. The support manager told us, and records showed that following the QAA a record of actions to be taken was made. We found one person' QAA did not have dates when action should be completed and an identified lead for the action. The support manager told us that normally team leaders would come down to the main building and complete the plan to say actions had been taken. She said she would normally also check on care plans to see if the action was complete but had been busy on other management tasks and so had not always had opportunity to carry out these checks. The registered manager told us the provider's quality assurance team also undertook similar quality checks, but these had only recently commenced and action plans had not been developed. However, current audit checks had not identified or rectified the issues highlighted regarding medicines or the incorrect application of the MCA and best interests legislation.

Some staff told us they felt there was not always enough management time. They said the support managers often seem stretched and busy. The registered manager told us the service should have a third support manager post but this was currently in abeyance. One person told us the registered manager had had a positive influence on the service, they told us, "(Registered manager) is very good. He has his finger on the pulse. He is very supportive."

The registered manager told us managing the service was a unique challenge. The physical make-up of the service, with bungalows spread out over a large site, along with staff employed to deliver personalised care made the service difficult to manage at times. He told us the service was currently half full and that if all the accommodation was occupied then there may be in excess of 250 staff, making the challenge even greater. He told us the philosophy of the service was to deliver individualised and person centred care. He was looking to establish each bungalow and person with an individual staff team, to fully respond to people's needs. He said that work was still progressing to get internal systems in place and to build positive relationships with external agencies.

Staff told us they were happy working in the service and felt well supported by the managers. Comments from staff included, "I love it; absolutely love it. There are some fantastic support workers"; "With the new management we are getting better back up. Communication was poor before, but they are coming up and checking everything is okay" and "It's been fantastic since the new manager joined. The managers are all very supportive – I've no issues at all in approaching any of them." A third person told us, "After an incident in a bungalow, I needed emotional support from a manager. They gave me this straight away and let me go home to calm down without putting any pressure on me, I really appreciated that."

People and staff told us regular checks were carried out around the complex. One person told us, "(Registered manager) comes over to check things out. He listens and takes notice of us. Things do get sorted out; quite easily sometimes." Another person told us, "(Registered manager) comes round. Comes over and checks on the bungalow and sees what needs doing and what can be made better."

The registered manager said meetings involving all the people using the service were rare, but that staff met with people on an individual basis each week, to check they were happy with things. Records confirmed these meetings took place.

A range of meetings involving staff also took place. There were weekly team meetings for each individual bungalow. Although some staff told us that, because other staff had been covering absences recently, these had not always taken place. Notes from these meetings showed they covered a range of issues including; encouraging healthier eating, ensuring that cleaning rotas were completed and working with the local behaviour support team. There were also regular team leader meetings. These covered practical issues related to care delivery, ensuring care plans had been agreed with people and ensuring training was up to date.

Requires improvement

Is the service well-led?

Records indicated developing staff relationships was an on going agenda item. Records from appraisals or other meetings indicated a lack of respect between staff. One staff member said, "The most challenging thing about working here can be staff relationships. There seems to be a lot of friction, especially towards staff who take a lot of cigarette breaks. Some of us have asked the managers during meetings to stop staff smoking on site but nothing has been done yet. I'm sure it will be, usually when we bring up a problem the managers respond really quickly." The registered manager said it was taking time but the staffing issues were improving and would continue to benefit as management time increased.

The registered manager told us annual questionnaires were used for people who used the service, relatives and stakeholders. The most recent questionnaires dated from December 2014. We noted that to date six questionnaires had been returned for people who used the service, four from relatives and three from stakeholders. Questionnaires for people who used the service were not in an easy read format and some had been completed by staff, aiding people to complete the forms. Some people had written "Do not understand" next to some of the questions. We spoke to the registered manager about this. He agreed the questionnaires could be more "accessible" and said he had fed this back to the provider's quality team.

The questionnaires looked at areas such as; how clean the homes were, the variety of food available, staff knowledge and whether people could raise concerns. Most questionnaires indicated people were satisfied with the care provided. Some people raised issues about staff team changes and the garden areas of the bungalows. It was not clear what action had been taken in relation to the matters highlighted. One comment from a relative stated, "Alexandra Park is very good, but I feel there is more that could be done for (person). But he has been settled.. and we have been very happy with the provision." Stakeholder questionnaires were again positive but did highlight that communication could be an issue.

With the exception of the issues highlighted with care plans, we found records were generally up to date and complete. Records contained within bungalows, checks and daily records were maintained, although the quality of daily records could vary.