FitzRoy Support

Huws

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 29 November 2017. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Huws is a nursing home for people living with a learning disability, physical disability and or autistic spectrum disorder. Huws accommodates 14 people across two separate buildings each of which have separate adapted facilities. At the time of the inspection 13 people were using the service and one person was in hospital.

A registered manager was present during the inspection and had been in post for six months. 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 care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy

At our last inspection in November 2015, the service was rated 'Good'. At this inspection we found that the service remained 'Good' in Effective and Caring and had deteriorated to 'Requires Improvement' in Safe, Responsive and Well-led.

Improvements were required in how people were supported with their prescribed medicines. This included safe storage, management and the checks and audits in place. Whilst the service was found to be clean, improvements were required on the prevention and control of infection. An action plan was required to meet the shortfalls identified in an NHS infection control audit completed in November 2017.

Risks associated with people's needs had been assessed but the plans in place to mitigate risks lacked clear and up to date information for staff. Support plans were not always followed by staff and information was lacking in places for staff to provide responsive and effective care and treatment.

The systems and processes in place to audit the quality and safety of the service required improvements to ensure staff were clear about their role, responsibility and accountably. The registered manager on the whole was aware of the shortfalls identified during this inspection and an action plan was in place.

Staff were aware of their role and responsibility of how to support people from avoidable harm and had

received safeguarding training. Improvements had been made in the recruitment of permanent staff and safe staff recruitment checks were carried out before staff commenced employment.

The environment and equipment was found to be appropriate and safe to meet people's needs. Staff had received training in health and safety. Accidents and incidents were recorded and analysed by the registered manager.

People's holistic needs had been assessed and planned for and there was good use of assisted technology to support people effectively.

Staff received an appropriate induction, refresher training was due for some staff and this had been planned for. The registered manager was aware the frequency of staff supervisions needed to be improved upon and had plans for this.

The monitoring of menus required improving to ensure they reflected people's needs, preferences and provided healthy balanced meals. Staff worked with external healthcare professionals to support people with their health needs and outcomes.

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. New improved documentation to complete mental capacity assessments and best interest decisions were being implemented.

Staff were kind, caring and compassionate and positive relationships had been developed with people who use the service. Staff had a good understanding of equality, diversity and human rights issues. People were treated with dignity and respect and involved as fully as possible in their care. People were supported to access advocacy services. People were supported with goals, aspirations, interests and hobbies. Information about how to make a complaint had been made available for people.

Staff were positive about the registered manager leadership and management and were complimentary of the positive changes they were making at the service.

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 has deteriorated to Requires Improvement.

Improvements were required in the administration, storage and management of medicines to improve safety.

Risks associated to people's needs lacked detail and guidance in places.

Improvements were required for the measures in place on the prevention and control of infections.

People were protected against the risks of experiencing avoidable harm. Staff were aware of their role and responsibility to safeguard people.

Accidents and incidents were regularly reviewed, assessed and investigated by the registered manager.

Is the service effective?

Good

The service remained Good.

People were supported by staff who had completed an induction, ongoing training and support.

People received meals based on their needs and preferences, oversight of people's food and fluid intake required some improvements.

Staff worked well with external healthcare professionals to meet people's health needs.

The principles of the Mental Capacity Act (2005) were followed when decisions were made about people's care. Deprivation of Liberty Safeguards were in place. New and improved documentation was being introduced.

Is the service caring?

Good

The service remained Good.

People were supported by staff who were kind, caring and compassionate and were knowledgeable about their needs.

People were treated with dignity and respect and their privacy was respected. People's diverse needs were known by staff and respected.

Relatives and people as far as possible, were involved with decisions made about their care.

People were supported to access advocacy services.

People's friends and relatives were able to visit whenever they wanted to.

Is the service responsive?

Requires Improvement

The service has deteriorated to Requires Improvement.

People's care records lacked specific detail and guidance in places for staff, additionally staff did not always following instructions provided.

People were involved in an annual review and received support with their goals and aspirations and to experience activities important to them.

People were treated equally, without discrimination and systems were in place to support people who had communication needs.

There was a complaint procedure available and presented an appropriate format.

Improvements were required in supporting people with end of life planning.

Is the service well-led?

Requires Improvement

The service has deteriorated to Requires Improvement.

Improvements were required with the quality assurance processes in place, including clear staff roles, responsibilities and accountability.

The registered manager was appropriately experienced and had a clear vision for improving the service based on best practice guidance.

Staff and on the whole relatives, were positive about the

leadership and management of the service. The provider's aims and values were respected by staff who in turn provided people with dignified, quality care and support.

Huws

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 29 November 2017 and was unannounced.

This was a comprehensive inspection that took place on 29 November 2017. The inspection team consisted of one inspector, a specialist advisor who was a registered nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. We also contacted commissioners (who fund the care people) of the service and some external health and social care professionals for their feedback about the service. We received information from two complimentary therapists, a social worker, dietician and a GP.

Due to people's communication needs we were unable to gain direct feedback from people who used the service. We therefore used observation to help us understand people's experience of the care and support they received. On the day of our inspection we spoke with one visiting relative and three relatives by telephone for their views about the service their family member received.

We spoke with the registered manager, a nurse, the housekeeper, two support workers, two new support workers and briefly with three agency workers. We looked at all or parts of the care records of four people along with other records relevant to the running of the service. This included the management of medicines, quality assurance audits, training information for staff and recruitment and deployment of staff, meeting

minutes, policies and procedures and arrangements for managing complaints.

After our inspection we contacted an additional relative via telephone and asked them for their views about the care and support their family member received.

Requires Improvement

Is the service safe?

Our findings

Improvements were required with how people's prescribed medicines were managed. One relative told us how they had concerns about how their family member received their medicines. This included not receiving their medicines on several occasions during 2017 which they felt impacted on their health and wellbeing.

We were aware of medicine errors that had occurred in March and August 2017. The registered manager told us there had been a further three medicine errors during the month of November 2017 in relation to two people who used the service. Two errors were of medicines not given for one person and the third could not be determined if this was a missed medicine or an error with the stock check. These errors had been reported to the local authority safeguarding team for investigation. When we checked people's medicine administration records we found one person's medicines had not been signed to confirm they had been administered. We checked this person's medicines and found the medicine was missing from the blister pack for that day, which suggested the person had been given their medicines but the member of staff had not signed to confirm this. We spoke with the registered manager about this. They said the systems they had put into place, should have picked up this issue but it had not, and they would follow this up.

The temperature of the central room used to store medicines were taken and records confirmed these were within acceptable limits. However, medicines were also kept securely in people's bedrooms but not all bedroom temperatures were taken. The thermometer used to record room temperatures did not give consistent readings when we checked; they varied by up to two degrees. This meant there was a risk medicines were not stored at the correct temperature impacting on their effectiveness. We found liquid medicines and topical creams were not always labelled with the date of opening. These medicines have to be used within a specific time from opening, without them being dated staff would not know the expiry date, which again could impact on their effectiveness.

We observed the administration of medicines and saw staff stayed with people and monitored them closely until they were satisfied they had taken their medicines. A member of staff was administering the morning medicines until around midday. They said this was unusual and the medicines were normally given by about 10.30am. However, information received from the local Clinical Commissioning Group advised they found the same issue during their audit visit in June 2017. This is a concern because there needs to be sufficient time in between medicines being administered to ensure the person does not experience any adverse reaction. The registered manager said they were aware of this and a review meeting had been arranged with the home's clinical lead to discuss what improvements were required.

Staff had the required information to safely administer people's medicines, this included a photograph of the person to aid identification, a record of allergies and the person's preferences for taking their medicines. Protocols on the whole were in place for medicines which were prescribed to be given only as required. Where these were missing, action was being taken to address this. Staff had received training in medicines management and the registered manager was in the process of completing staff competency checks. The registered provider had a medicines policy and procedure available for staff. The new clinical lead at the

service along with the local Clinical Commissioning Group pharmacist had made plans to review the medicines audits and checks in place to review how these could be improved upon.

Improvements were required with the systems and processes in the prevention and control of infections. A NHS infection control audit had been completed in October 2017 that identified some areas of improvement. The registered manager was in the process of developing an action plan to address these improvements. We spoke with the newly appointed housekeeper who told us about their role and responsibility to ensure the environment met the expected standards in hygiene and cleanliness. They were knowledgeable about cross contamination issues and had the cleaning materials and equipment required. We identified there were insufficient cleaning records in place used to monitor the cleaning that had been completed. The registered manager was aware of this and said they would be introducing appropriate cleaning schedules. Staff had received training in infection control and there was an infection and control policy and procedure available for staff.

Relatives were positive their family member received safe care and support. One relative said, "I do, absolutely feel [name of family member] is cared for safely."

Staff were aware of their role and responsibility to protect people from avoidable harm including discrimination. Staff told us they had received training to support them in keeping people safe and training records confirmed this. The registered provider had safeguarding policies and procedures in place to guide practice. From our records we were aware safeguarding issues had been appropriately reported and responded to. We identified improvements were required in how people were supported to understand their rights in relation to safeguarding including discrimination. This was because information was not available for people. We discussed this with the registered manager who agreed and said they would explore this.

Risks associated with people's needs had been assessed and plans were in place to advise staff of the action required to support people safely. However, some risk assessments lacked detailed and personalised information relating to how the person should be supported. For example, we noted in one person's care records it stated they had experienced a fall when using the shower tray. Their mobility support plan was evaluated following the fall and stated two staff should be present at all times to assist them to use the shower safely. However, the risk assessment stated that the brake on the shower tray should be applied, but did not state two staff were required. Whilst experienced staff were able to tell us clearly about the action they took to support people with risks, new staff relied on written documentation. We discussed the issues we identified with the registered manager. They agreed risk assessments required reviewing to ensure they provided staff with clear detailed information that was based on the individual person's needs.

Risk assessments were completed for a wide range of risks to which the person might be exposed, this included for use of equipment and choking. We noted recognised risk assessment tools were used in the risks related to the assessment of pressure sores and nutritionals risks. However, best practice guidance in relation to assessing risks with the use of bed sides was not used. This meant not all potential risks had been considered.

We observed one person being moved from a wheelchair to a trampette (small trampoline) by two staff using a hoist. They informed the person what they were doing, and showed awareness of maintaining safe positioning throughout. We observed clear signage in one person's bedroom and on the outside of the door, reminding staff that small items including gloves and wipes, must be kept out of reach at all times as there was a risk the person would put these into their mouth.

The registered provider had policies and procedures such as whistleblowing to support staff to raise any

concerns confidentially. Staff disciplinary procedures were also used when concerns were identified about poor care and treatment. People's care records were stored securely and information was shared with relevant external professionals where appropriate.

Individual plans were in place to support people in the event of an emergency requiring people to be safely evacuated. Checks were completed on the internal and external environment and premises, including equipment. We found these checks were up to date and the environment and equipment seen was appropriate and in working order.

Some people experienced anxiety that affected their mood and behaviour. We noted people did not have positive behavioural support plans in place to inform and guide staff of how to support them during these times. The registered manager said they had identified the need for staff to receive training to support them to understand people's behaviours more effectively. Some staff had received appropriate accredited training and further training had been arranged for all staff to complete this in January 2018. One staff member who had completed training in behavioural strategies was positive that this was useful and gave them greater understanding and awareness.

Relatives told us how the service had experienced changes within the staff team resulting in some staff leaving and the use of agency staff. One relative said, "Recently it's been short staffed, they've been using agency staff a lot. New staff are coming in, we will see how it goes." Another relative said, "Since May 2017 there has been a lot of changes with experienced staff leaving."

The registered manager told us four new care staff had recently been appointed and in addition a new clinical lead and permanent nurse. They were positive this would reduce the need to use agency staff. The registered manager told us how they assessed people's dependency needs which determine the staffing levels provided. They said they had a flexible approach to staffing and increased it when required.

On the day of our inspection one staff member had called in sick, one staff member was supporting a person in hospital and two further staff had health appointments. A staff member on their day off came to cover a shift and agency staff were called in. Staff said the staffing levels were normally good and the shortage of staff on the morning of the inspection was an exception. Agency staff confirmed they had received an induction and two agency staff who had worked at the service on a regular basis told us they enjoyed working at Huws.

We reviewed three staff files and records showed safe recruitment procedures, such as criminal record checks, proof of identity and reference checks had been completed. Checks were also carried out to ensure nursing staff were appropriately registered with the Nursing and Midwifery Council. This protected people as far as possible from the risk of unsuitable staff being employed. Through discussion with the registered manager it was clear they had a commitment to promote equality and diversity through staff recruitment to ensure they employed a diverse staff team.

The registered provider had systems and processes in place to effectively manage accidents and incidents. A relative told us of an accident their family member had been involved in. They said they were informed of the accident immediately and described staff response as, "Very good, they made changes to the door to prevent it happening again."

Staff were aware of their responsibility to respond to any incident or accident and said any concerns or incidents were discussed at staff handover meetings and communicated with the registered manager. Records confirmed on the whole appropriate action was taken such as investigating incidents to help

prevent them happening again. Senior managers within the organisation received regular reports from the registered manager of any incident and accident. This meant there was continued oversight by the registered manager and senior managers to ensure action was taken to mitigate further risks.

Good

Is the service effective?

Our findings

People received care and treatment based on their holistic needs. Relatives told us they had been involved in their family member's assessment and ongoing reviews of the care and treatment provided. Records viewed confirmed what we were told.

From viewing people's care records we found people's needs and choices had been assessed and care, treatment and support was delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. An example of this was epilepsy society guidelines were available for staff in relation to first aid for epilepsy. The registered manager was experienced in learning disability services. They had a clear understanding and knowledge in best practice, whereby they promoted independence and social inclusion. Staff told us they found the registered manager to be informative and had introduced new methods and approaches that were having a positive impact on people.

Assisted technology was used effectively to promote people's independence. For example, some people required close observations to monitor their health and well-being. The use of alarms and sensors to alert staff to seizure activity was in place for some people and door alerts were used for some people to alert staff when they were independently mobile.

Relatives told us they felt staff were sufficiently trained to support their family member. One relative said, "Staff give good care and attention, not an easy job. [Name of family member] always seems to be happy, their quality of life has improved at Huws. Staff contact me with any queries or concerns." Another relative said, "Yes there are new staff coming in. They are shadowed. If I see anything like new staff being unsure or hesitant I will let them [registered manager] know."

Two new staff told us about their induction and confirmed they felt this was supportive and informative. Records confirmed staff had received a structured induction which included the Care Certificate. The certificate is a set of standards that health and social care workers are expected to adhere to. Staff told us they received opportunities to meet with their line manager to review their work, training and development needs. The registered manager said they were aware the frequency of these meetings had dropped, but showed us a plan they had developed to improve this.

Staff told us about the training they had received and were confident this was appropriate and supportive. Training opportunities included, end of life training, epilepsy awareness and learning disability. We reviewed the staff training plan that showed some minimal gaps in staff requiring refresher training. There was a valid reason for this and plans were in place for staff to receive this training.

Relatives told us their family member received sufficient to eat and drink and they considered the choice and quality of meals to be good. One relative said, "There seems to be a good choice, it's nice, it's like home cooked food." Another relative said, "The food's cooked from scratch."

Staff told us they involved people in menu planning and used pictures of different foods to aid choice

making. We did not see any written records to confirm this. There was no visual menu available to support people to know what the meal choices were. Whilst staff said there was a menu in each of the three areas of the service this was not found to be the case in every area. One example of a menu showed a good variety of meals were provided. However, another menu for another area showed meal options had been crossed off with an alternative provided. When we enquired about this we were told it was due to staff's lack of organisation and planning. We asked the registered manager who had oversight of the menu to ensure meals had been considered for individual needs, preferences and healthy eating. The registered manager said this was the responsibility of nursing staff; however there was nothing to confirm this occurred. This meant there was a lack of oversight and staff accountability.

We found adequate stocks of food in the kitchens and these were stored appropriately. Experienced staff were aware of the dietary needs of the people they cared for and their preferences. We observed how people were present in the kitchen during the planning and preparation of meals, this provided an opportunity for people to be involved in the activity.

Assessments had been completed with regard to nutritional needs and consideration to religious and cultural needs. Staff had clear instructions about who had a fortified diet. People's weights were monitored and action was taken such as a referral to the GP or dietician when concerns were identified.

Staff completed 'traffic light assessments for people with a learning disability' to provide information about the person's care needs to be used in the event of an emergency admission to hospital.

Relatives were positive their family member's health needs were assessed, monitored and responded to effectively. One relative said, "Yes, [name of family member] has regular health visits. Staff keep us up to date."

We received positive feedback from two healthcare professionals about how staff met people's healthcare needs. One professional said, "I meet with one of the nurses on a routine basis every fortnight and in general if residents need medical attention in between times, the staff coming with them knows what is going on." This professional added, "The staff are very helpful and knowledgeable and will seek advice from GP/other health professionals when necessary." Another healthcare professional said, "Thanks to the dedication of the team at Huws, a patient now (in my opinion) has a better quality of life and their health needs are well managed."

People's care records confirmed staff worked well with a variety of external healthcare professionals to meet people's health needs and outcomes effectively. For example, the following external professionals were involved in some people's health needs; a neurologist, GP, dietician, speech and language therapist, dentist and epilepsy nurse specialist.

The premises were adapted to make them accessible to people using wheelchairs; this included the use of ceiling track hoists, specialist baths and showered chairs. People had their own individual slings and people's bedrooms were decorated and furnished individually and reflected people's interests.

Throughout the inspection we observed staff gained people's consent before providing care and support. Staff responded well to people's non-verbal responses, and respected and acted upon people's wishes.

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. We checked whether the service was working within the principles of the MCA.

We found mental capacity assessments had been completed where people lacked mental capacity to make specific decisions. Whilst support plans instructed staff of how to meet people's needs followed the MCA assessment, it was not clearly documented how decisions had been made. We discussed this with the registered manager who showed us new MCA documentation that was in the process of being implemented. This was much improved and included clear decision making processes and fully reflected the principles of MCA. Staff were aware of the principles of MCA and DoLS and told us they had received training in these areas. The registered provider had an MCA and DoLS policy and procedure to support staff.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Records showed DoLS applications had been made for some people who had some restrictions on their freedom and liberty due to their level of needs and safety. One person who had been granted an authorisation to restrict them had conditions imposed. The registered manager was aware of these and had taken some action to address these. We noted where people had authorisations in place, the person's care records did not include a support plan to advise staff of this. The registered manager said they were aware of this and had plans in place to include this when care records were reviewed.

Some people's needs associated with their learning disability could affect their mood and behaviour and they required support from staff to manage this effectively. Staff had started to receive training in an accredited physical intervention programme. The registered manager said improvements were required in up skilling the staff team in assessing and understanding people's behaviour more effectively.

Good

Is the service caring?

Our findings

Relatives spoke positively about the approach of staff. One relative explained how a member of their family had been unwell requiring hospitalisation several times, and told us how their family member living at Huws had been supported by their keyworker to visit and was grateful for this. A keyworker is a member of staff that has additional responsibility for a named person living at the service. Another relative said, "Staff are definitely caring, in the way they talk to and treat residents. I am very thankful and think [family member] gets excellent care." A third relative said, "Staff are gentle with [name of family member] encouraging, kind but firm. They give them time."

We received positive feedback from external professionals who were complimentary about the staff being kind and caring. One professional said, "Huws is warm and welcoming and the staff know the patients well, with a real fondness and care demonstrated." Another professional said, "The staff care deeply about the residents and have good relationships with them."

Staff showed understanding and empathy for people and supported them in a caring manner. On the whole we found staff engagement with people to be positive, respectful and caring. For example, a staff member explained how one person cannot see sensory lights but likes a massage and relaxing music. They explained that the person's mood was assessed and this influenced the activity offered. Another person had a hand and foot massage before spending time sat on a trampette, where they were observed to be enjoying bouncing and playing their guitar. We noted in this person's care records that this was a favourite activity and was important to them.

We saw people relaxed within the company of staff, in particular experienced staff, this was demonstrated by people who used the service smiling and laughing. Some people deliberately sought out certain staff to spend time with and showed great affection towards them. This clearly demonstrated people had developed strong and positive relationships with staff.

Staff spoke positively and respectfully about the people they supported, clearly demonstrating a good understanding of people's preferences, personal histories, routines and what was important to them. We observed staff used good communication skills, showing a good awareness of people's sensory needs and communication preferences.

Staff were positive about their work. One staff member said, "I love working here it's more than a job for me." The registered manager spoke highly of the dedication shown by staff and told us how staff went the extra mile such as working on their days off or how they stayed longer to ensure people's needs were met.

The registered manager told us how people's diverse needs were assessed and considered in the care, treatment and support provided. Examples were given how several people were supported with their religious faith and were supported by staff to attend places of worship. The registered manager said the provider had a clear values and behaviour framework they expected staff to adhere to. Additionally, a new sexual rights policy had been introduced and an anti-discriminatory policy was in place that protected

people. Staff were aware of equality, diversity and human rights issues. One staff member said, "We respect people are individuals and strive to understand and support people in what's important to them."

People had access to information about independent advocacy services and staff were aware of this information. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. There are different types of advocates and at the time of our inspection the registered manager said three people were receiving support from an Independent Mental Capacity Advocate.

Relatives told us they were invited to attend an annual review meeting to discuss their family member's needs and the service they received. We saw examples of review meetings with the involvement of the person and their relative and relevant external professionals.

Relatives spoke confidently about how staff respected their family member's privacy and dignity. One relative said, "Privacy and dignity is respected very much so, it's not easy. [Name of family member] is always dressed nicely." Relatives also told us independence was promoted as fully as possible. One relative said, "Yes I think impendence is promoted all the time. They (staff) provide options."

Staff told us the registered manager had a good approach in developing people's independence. One staff member said, "The manager has been challenging us, not in a negative way but getting us to think about how people can be involved more." An example was given about how staff were supporting people to be included with everyday tasks such as using hand over hand to pour cereals into a bowl and to pour drinks. These small steps were significant for people and were important in developing their independence, confidence and self-esteem.

People's information was stored securely and managed in line with the Data Protection Act. Staff demonstrated an understanding of the importance of respecting confidentiality. Relatives told us there were no restrictions on visiting their family member and said staff were welcoming when they visited.

Requires Improvement

Is the service responsive?

Our findings

People's care records contained information about the person and what was important to them, things they liked and how the person communicated they were unhappy or wanted to complain. Support plans provided detailed information about the care the person required and their preferences which was largely personalised and provided a clear picture of the person. However, many were originally written over three years previously. Whilst there was some information in the monthly evaluation records as to changes to the person's care, it was necessary to sift through considerable information to be certain of the care the person required. Interventions were not always updated. In addition, there was some repetition. A member of staff commented that when they had commenced work in the service, they had found there was a lot of information contained in the care records which made them difficult to read and some information was no longer relevant. The registered manager told us people's support plans required a complete review to ensure staff had access to up to date information that was clear and informative. They had plans in place to start this work.

We found examples of support plans associated with people's healthcare needs that lacked detail and guidance for staff. Support plans for skin care were not always detailed in respect of the action staff should take to prevent pressure ulcers. They did not always reflect the person's level of risk. For example a support plan stated a person should be re-positioned two hourly if their skin was 'breaking down.' This indicated a reactive rather than proactive approach. Pressure relieving mattresses were used to prevent the development of pressure ulcers but were not always recorded in the person's support plans. We checked the records staff used to document daily interventions and found records of re-positioning were not completed regularly. One person's support plan stated they required two hourly re-positioning, however, the records for repositioning was not in accordance with the support plan. When we asked a member of staff about the frequency of re-positioning for that person they said they re-positioned the person "every three hours or so." They said the person did not need more frequent re-positioning because they "were in a comfy chair." This meant there was a risk to people's skin care because staff did not always follow guidance and instruction.

Support plans for the management of people who were receiving their nutrition through a tube into their stomach, provided clear information about the care of the tube and equipment and the action staff should take if the tube needed replacing. There was also information about the feeding regime supplied by the community dietetic service. However, we saw staff recorded water flushes given but did not always document the administration of the feeds with start and finish times and volume administered. Nor was daily tube care always documented. Clear documentation of care and treatment provided is required to effectively monitor people's needs.

Relatives told us how they and their family member as fully as possible, received opportunities to be involved in discussions and decisions about how care and support was provided. One relative said, "Annual reviews are itemised and plans for the next year are made."

People's care records demonstrated people had an annual person centred plan review meeting. Information showed there was a good understanding of person centred approaches to reviews and best

practice guidance in this area had been followed. The person was at the heart of the review meeting and discussions and actions were agreed with how they would be supported with dreams, goals and aspirations. For one person, their goal was to have regular contact with their family and to be supported with activities, interests and hobbies important to them. This included going swimming, and attending the theatre and cinema. Records confirmed this person had been supported as described.

Positive comments were received from external professionals. Comments included, "I have always found the staff at Huws extremely resident-focused, including the residents in activities and household conversations." And, "I visit weekly to offer Aromatherapy and Reflexology and the staff are very helpful, assisting the residents for their treatments as soon as is possible."

The registered manager told us they were aware of their responsibilities in relation to, The Accessible Information Standard. This standard expects provider's to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss. Staff had received training in people's preferred communication methods. The registered manager told us they wanted to improve the visual communication such as signage used around the service to support people more effectively.

Communication support plans provided information about the facial expressions and movements which people used to express their wishes. One person's care records contained information on the principles of 'intensive interactions' which said staff should use to communicate with the person. A person was registered blind and their support plan provided information for staff about how to interact with the person and the necessity of providing verbal information throughout caring interactions.

We observed staff used positive communication and listening skills that demonstrated they clearly understood people's communication needs. We observed how a staff member conversed with a person whilst supporting them with an activity. The staff member informed us what a particular noise the person made meant, which enabled us to communicate appropriately with this person. Another member of staff told us Makaton a form of sign language was used to support people with their communication needs. Pictures and objects were also used to describe activities and promote choices. Some people used an iPad (a handheld computer device) to help them communicate and used 'Facetime' as a method to keep in contact with family. We found the service user guide available for people that explained what they could expect from the service was presented in an appropriate format for people.

Relatives told us their family member received opportunities to participate in activities of interest to them. One relative said, "[Name of family member] goes to college, has outings and does activities. They like hiding under the parachute and playing ball in the ball pool. They go swimming and bowling. Their keyworker takes them shopping and gives choices."

Staff told us they thought people had lots of activities and mentioned arts and crafts and also said, "They go out quite a bit." They said the amount of activities had increased since the new registered manager had started at the service. The registered manager showed great commitment in developing new and creative opportunities for people, including greater social inclusion. The registered manager said, "Some people living here are young adults and should be out and about experiencing lots of opportunities and leading fulfilling, active and fun lives." We were told about a person who had attended a concert with the registered manager, the evening before our inspection.

People had access to a sensory room that provided relaxation and tactile and sensory activities and stimulation. External complementary therapists visited the service and provided people with aromatherapy and reflexology. An activity planner showed people received opportunities with activities in baking, listening

to music and ball games. The service had wheelchair accessible transport. Staff told us the annual holidays people had enjoyed that were based on people's interest and hobbies. On the day of our inspection we observed two separate cooking / baking sessions that people were involved in. People were also seen to sit in front of the television, listen to music and freely move around the service.

Relatives told us that if they had any concerns they would raise them with staff. One relative said, "I'm very happy. I can't praise the service enough." One relative told us they had raised some concerns with the registered manager and a formal complaint was being investigated.

Although a basic end of life support plan was in place for a person, it did not provide personalised information about their wishes and the action for staff to take. The registered manager told us they were aware for the need to further develop people's end of life support plans and had plans in place to do this.

Requires Improvement

Is the service well-led?

Our findings

There was a system of audits and processes in place that checked on quality and safety. These were completed, daily, weekly and monthly for areas such as health and safety, medicines and accidents / incidents. However, some improvements were required to ensure these systems were robust, including clear staff roles, responsibilities and accountability for completion and oversight.
Representatives within the organisation also completed checks and quality audits and an improvement plan was in place with actions based on the outcome of these checks. We looked at the action plan and found on the whole areas identified in our inspection had been raised as an area that required improvements.

The registered manager said there were not regular opportunities for people to give feedback or be involved in the development of the service. We saw two meeting records completed in 2017 but the format was not appropriate for the needs of people using the service. The registered manager agreed more creative ways were required to involve people more effectively in the service.

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

The registered manager told us now new staff had been appointed they had a clear vision and plan to move forward with improvements they had identified as required. This involved improvements to people's care records, documentation and record keeping, increasing staff's understanding and awareness of people's behavioural and communication needs and increasing opportunities of social inclusion. The registered manager said, "I want to develop a staff reflective practice approach, where we can grow and develop together as a team. I'm reviewing roles and responsibilities to ensure there are clear structures and lines of accountability."

Relatives told us about changes in staffing that had occurred during 2017 and how this had been unsettling at times. However, on the whole relatives were confident the appointment of new staff had started to have more of a positive impact. One relative said they knew who the registered manager was and they could easily approach them. This relative said, "Yes contact is good, I just knock on their door." Another relative told us communication was open and transparent. This relative said, "I'm am actively involved in my family member's care, staff appreciate my involvement and are happy for my input." A third relative was less positive about the leadership and management of the service and said the communication by the registered manager could be better.

Feedback from external professionals was positive about the registered manager who was described as wanting to make improvements at the service. The registered manager was suitably qualified and experienced and had a good knowledge of best practice guidance that they used to inform them of what

was required to make improvements at the service.

Staff were positive the registered manager was making improvements at the service. One staff member said, "The manager has got some positive ideas, I've learnt a lot already from them." Another staff member said, "The manager is very good, helpful and approachable, they are around all the time, they pick up on things and address them, nothing gets by them." A third member of staff said, "What I like about the manager is when they come on duty they come around and say hello to everyone and goodbye when they leave, I think that's respectful and a nice touch."

Staff gave examples of the positive changes that had started to be implemented and made reference to additional training to increase staff's understanding about people's behaviour and communication. One staff member told us of how they had been asked to start work of collating information about a person to be used in their care records. This staff member said, "The manager wants people's support plans re written to make them more person centred and up to date." This member of staff showed us the work they had started that confirmed what we were told.

The registered manager told us they used staff meetings, one to one supervision meetings and observations to assure themselves staff were appropriately supported to provide effective care and support.

The service had submitted notifications to the Care Quality Commission that they were required to do and had policies and procedures in place to manage quality care delivery and health and safety. The ratings for the last inspection were on display at the service and available on the provider's website.