Truecare Group Limited

Twynham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over two days on 26 and 27 June 2016. The inspection was unannounced.

Truecare Group Limited are part of the Choice Care Group. Choice Care Group provide both residential and supported living services for people with learning disabilities and mental health disorders, with a particular specialism in working with individuals who have highly complex needs and may behave in a way that is challenging to others. Twynham provides accommodation, care and support for up to seven adults. At the time of our inspection there were seven men living within the service. The home is situated close to New Milton town centre. It has seven individual rooms arranged over two floors. The home does not have a lift and is so is not suitable for people with restricted mobility. Three of the rooms have ensuite facilities. There is a large kitchen and a lounge / dining area and a conservatory. This leads out to a garden and barbeque area, activity workshop and a vegetable garden. There was a covered smoking shelter in the garden. The home has its own vehicles to assist people to access leisure, recreational and educational activities in the community.

The service had a registered manager although they were not currently working within the service. 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 and associated Regulations about how the service is run. A new manager had been appointed and was in the process of applying to the CQC to register.

People were not always given foods in line with their specific dietary requirements. Staff were not always present in the dining room whilst people were eating and drinking. This placed them at increased risk of harm. Other risks were appropriately assessed and planned for and staff demonstrated a good understanding of these.

Whilst staff supported people in a kind, sensitive and respectful manner, we felt some aspects of how people's care was delivered in a generic manner and not always provided in a person centred way. It was not always clear that some of the risk reduction measures that were in place were based upon the needs of people using the service or balanced with people's rights to a private life.

Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when the local authority approve an application to restrict a person's liberty to protect them from harm. Applications for a DoLS had been approved by the local authority for four of the seven people living at Twynham but the provider had not notified the Commission.

Policies and procedures were in place to ensure the safe handling and administration of medicines. However, the information available for "as required" (PRN) medicines, could be more detailed and staff had

not always signed for medicines when they were administered.

Staff had received training in the Mental Capacity Act 2005 and they were able to demonstrate an understanding of the key principles of the Act. However staff had not always completed an assessment of people's capacity to consent to aspects of their care and support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which are part of the Mental Capacity Act (MCA) 2005 and apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for. Where authorisations had expired, we did note that staff had not always applied for a new authorisation in a timely manner.

Whilst staff were trained in the use of physical interventions, but in the case of two staff this was not up to date. This is now booked for July 2016. Other training relevant to the needs of people using the service was in place and generally up to date. New staff received a comprehensive induction which involved learning about the needs of people using the service and key policies and procedures. Staff received regular supervision and an annual appraisal.

Although some people could display behaviours which challenged, staff had taken steps to understand the potential triggers and had implemented methods to manage and de-escalate these behaviours in the least restrictive way possible. Incidents and accidents were reviewed and monitored. This helped to ensure the behaviour management strategies in place remained effective and helped to keep people safe.

Staffing was adequate to meet people's needs and recruitment practices were safe and relevant checks had been completed before staff worked unsupervised.

Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team.

People told us they received effective care and from speaking with relatives, staff and reviewing records, it appeared that the service achieved positive outcomes for people.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs. People were involved in decisions about what they ate although we did note that they could be more involved in preparing their meals.

Where necessary a range of healthcare professionals including GP's, community learning disability nurses, speech and language therapists and dentists had been involved in planning peoples support to ensure their health care needs were met.

People told us they were supported by staff who were kind and caring and the atmosphere within the home was calm and relaxing. Staff engaged people in meaningful conversations but were also seen to share a laugh or a joke with them when this was appropriate. Staff were also gently challenging when this was required, which helped to prevent people's anxieties from escalating.

Staff had a good knowledge and understanding of the people they were supporting. Staff were able to give us detailed examples of people's likes and dislikes which demonstrated they knew them well.

People were supported to take part in a range of activities and make choices about how they spent their

time.

Complaints policies and procedures were in place and were available in easy read formats within the communal areas of the home. People and their relatives told us they were confident that they could raise concerns or complaints and that these would be dealt with.

Relatives and staff spoke positively about the manager. There was an open and transparent culture within the service and the engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements. There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always given foods in line with their specific dietary requirements. Staff were not always present in the dining room whilst people were eating and drinking. This placed them at increased risk of harm.

Systems were in place to manage medicines safely but plans for 'as required' medicines could be more detailed and person centred. Staff had not always signed to confirm that they had administered people's medicines.

People were supported by sufficient numbers of suitably qualified, skilled and experienced staff who knew how to recognise and respond to abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Care plans did not always include an assessment of people's capacity to consent to key aspects of their care and support.

Whilst staff were trained in the use of physical interventions, in the case of two staff this was not up to date. Other training relevant to the needs of people using the service was in place and generally up to date. Staff received regular supervision and an annual appraisal and were appropriately inducted to the service.

People were supported to eat and drink in sufficient quantities and had access to healthcare professionals when this was required.

Is the service caring?

Good

The service was caring.

People told us they were supported by staff who were kind and caring and the atmosphere within the home was calm and relaxing. Staff were also gently challenging when this was

required, which helped to prevent people's anxieties from escalating.

Staff had a good knowledge and understanding of the people they were supporting. Staff were able to give us detailed examples of people's likes and dislikes which demonstrated they knew them well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst staff supported people in a kind, sensitive and respectful manner, we felt some aspects of how people's care was delivered in a generic manner and was not always provided in a person centred manner.

People had access to activities of their choice.

Complaints policies and procedures were in place and people and their relatives were confident they could raise concerns or complaints and these would be dealt with.

Is the service well-led?

Requires Improvement

The service was not always well led.

Notifications had not always been submitted to the Care Quality Commission when required.

The manager was well respected by the staff team.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

Twynham

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 checked 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 was an unannounced inspection which took place over two days on 26 and 27 June 2016. On the first day there were two inspectors. The second day was undertaken by one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with the manager, the assistant area director and four support staff. We also reviewed the care records of four people, the records for two staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

We spoke with six of the seven people using the service and spent time observing interactions between staff and people. Following the inspection we spoke with three relatives and obtained the views of two health and social care professionals about the care provided at Twynham.

The service was last inspected in November 2013 when no concerns were found in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Twynham. One person told us, "I feel safe here, that's the best thing". All of the relatives we spoke with told us their relatives received safe care.

Individual risk assessments had been completed for people who used the service and covered activities and associated health and safety issues both within the home and in the community. For example, we saw completed risk assessments in relation to self-neglect, behaviours which might challenge others, cooking and other household tasks. People living with epilepsy had risk assessments in relation to this which were suitably detailed. Where people were at risk of choking due to difficulties swallowing, there were risk assessments in place which included guidance about how to provide emergency first aid. Overall staff were generally well informed about the risks to each person and told us the risk assessments provided them with the information they needed to manage the risks and protect the person or others from harm.

However, we found that some people's risks were not being adequately managed. Two people living at the service required a modified diet due to their risk of choking when eating. Their care plans stated that they required a soft diet and that their food should be cut up into small pieces to avoid the risk of choking. On the first day of our inspection we noted that one person was given a meal not fully in keep with their prescribed modified diet. We were also concerned that for a period of five minutes the person was left to eat independently whilst staff attended to other tasks. We were concerned that this might mean a delay in staff providing emergency first aid in the event of the person choking. We spoke with the manager about this. We were advised that the person had been given an incorrect meal by a member of staff who had just returned from an extended absence and so was not aware of the changes to the person's diet. We asked that they ensure that arrangements were in place to ensure that staff returning from leave were given an adequate handover and were fully updated about changes to people's needs. On the second day of our inspection, we again, however, had concerns that part of another person's meal was not in keeping with their prescribed diet. We saw that they had eaten most of a packet of crisps. Guidance displayed in the kitchen stated that crisps were a high risk food for this person and should be avoided. Again for a short period of time, there were no staff in the dining room monitoring that this person was eating and drinking safely.

Staff were not always following risk management strategies. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Some of people within the service could at times express themselves through displaying behaviours which could challenge others which included physical aggression towards others or towards objects. Where this was the case people had positive behavioural support plans and a risk management plan in place. These plans had been developed with the input of the provider's psychology team and included a description of the potential behaviours, the possible triggers, justification for intervention, and the agreed techniques to be used. Where physical interventions were required staff used an approach accredited by the British Institute of Learning Disabilities (BILD). The support plans viewed were clear and stressed the importance of taking the least restrictive actions first, for example, redirecting the person to another activity, avoiding triggers and how best to talk to the person to de-escalate the situation. It was very clear that physical interventions were

to be used as a last resort only and for the least amount of time. Behaviour observation charts (BCO) were completed when there were instances of behaviour. These were reviewed by the manager and the in-house psychology team. To ensure appropriate responses were taken by the staff especially when using physical interventions. All of the staff we spoke with told us they felt they were competent and confident in the use of these techniques and gave us examples of how they used these when supporting people to protect the individual and others from harm.

Incidents and accidents were reviewed and monitored. The use of physical interventions was monitored by the manager to review antecedents to the incident, the behaviours involved and the consequences of the incident. This helped to identify triggers or trends and helped to ensure the behaviour management strategies in place remained effective and helped to keep people safe.

There were policies and procedures in place to ensure the safe handling and administration of medicines. Medicines were only administered to people by staff who had been trained to do this and who underwent and annual review of their skills, knowledge and competency to administer medicines safely. The administration of medicines was always witnessed by a second staff member. We reviewed all seven people's medicines administration record (MAR). These contained sufficient information to ensure the safe administration of medicines to people. Medicines were stored safely in a locked medicines cabinet. Room temperatures were being taken daily to ensure the medicines were being stored within recommended temperature ranges. No one at the service was receiving covert or hidden medicines and no-one administered their own medicines or required controlled drugs. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971 as there can be a risk of the medicines being misused.

Some areas of how medicines were managed could improve. Whilst some information was available for "as required" (PRN) medicines, this did not provide sufficiently personalised guidance for staff about when these should be given. Detailed and personalised PRN protocols help to ensure that all staff are able for example, to provide a consistent response to people's individual signs of pain where people were no longer able to communicate this or to manage episodes of anxiety or agitation. We also noted that staff had not signed for one person's medicine on two occasions in the past week. Medicines audits showed that this had been identified as an area requiring improvement in the two previous months also.

Staffing was adequate to meet people's needs. The numbers of staff on duty was determined by people's care needs assessment. Currently there were a minimum of four staff on during the day and two waking night staff. Additional staff were rostered to ensure people had the extra support they needed to undertake an activity in the community or to attend health appointments for example. Shifts were organised to help ensure that there were sufficient staff to provide activities, that drivers were available and staff trained in using physical interventions and the administration of medicines. All of the people, relatives and staff we spoke with told us they felt staffing levels were adequate to meet people's needs safely. A relative told us, "There always seems to be plenty of staff". Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. Interviews took place at the service and involved observing how the prospective staff member interacted with people using the service. These measures helped to ensure that only suitable staff were employed to support people in their homes.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The organisation had appropriate policies and procedures and information was readily available on the local multi-agency procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns

and to taking action to ensure people's safety. One member of staff told us, "If a member of staff is being out of order to a service user, you need to say or you are just as bad as them". All of the staff we spoke with were aware of the organisations whistle-blowing policy and were clear they could raise any concerns with the manager of the home, but were also aware of other organisations with which they could share concerns about poor practice or abuse.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care. One person said, "Yes the staff know what they are doing". From speaking with relatives, staff and reviewing records, it appeared that the service achieved positive outcomes for people. For example, we were told about one person had enjoyed a holiday away for the first time. This person also no longer spent long periods of time in their bedroom, but appeared to feel at ease in the communal areas of the home. One person was being supported to go out on their own in the community after many years of not wanting to go out at all. One relative said, "We are very happy, it's by far the best place he has been, the care and staff are far better than anywhere else, we've seen a change in [their relative], they turned him around, they are dedicated staff". Another relative said, [the person] has made a lot of progress, they are speaking more and no longer aggressive, they are always calm, they are a pleasure to have home". The manager told us people had thrived within the service due to the consistent approach of the staff team. Our observations indicated staff had a good knowledge of the people they supported. We observed staff working in a professional manner and communicating with people effectively according to their needs. Staff told us they felt the service delivered effective care. One staff member said, "If I had to be in a home, I would like to be in this home".

The Mental Capacity Act (MCA) 2005 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. Staff had received training in the MCA 2005 and they were able to demonstrate an understanding of the key principles of the Act. Staff understood that where people had capacity to make decisions, these must be respected including any unwise decisions they might make. They were aware that any actions taken must be in the person's best interests when they lacked capacity to make informed decisions. Where people were subject to restrictions or were not free to leave the home unescorted due to concerns about their wellbeing, mental capacity assessments had been undertaken to establish whether they understood why the safeguards were in place. However we did note that care plans did not always include an assessment of people's capacity to consent to other aspects of their care and support. For example, one person had an audio monitor in their bedroom so that staff could monitor whether they might be having a seizure. We were advised that this had been agreed as being in their best interests, but there was no mental capacity assessment regarding this decision.

We recommend that the service ensures that at all times; the preparation of people's care plans includes an assessment of their capacity to consent to aspects of their care and support in line with the Mental Capacity Act 2005 Code of Practice.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the Mental Capacity Act 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Five people were subject to restrictions or were not free to leave the home unescorted due to concerns about their wellbeing and

appropriate applications for a DoLS had been approved or submitted. Improvements were, however, needed to ensure that where authorisations had expired, staff had always applied for a new authorisation in a timely manner.

Some staff were not up to date with all of training that the provider deemed to be essential to meet the needs of people using the service. For example, on an annual basis staff were required to complete training in how to safely use physical intervention to de-escalate behaviour which might challenge others. In two cases, including one acting team leader, this training was overdue. We spoke with the assistant area director about this. They explained that staff had previously been booked to take part on this training but had needed to be withdrawn to maintain the staffing levels in the home to keep the service safe and effective. They told us this training was now booked for the two staff and would take place in July 2016.

The provider had employed a new training manager who would be responsible for overseeing the delivery of the training programme. Staff currently completed a range of training which included fire training, first aid, infection control, safeguarding people and equality and diversity. This was generally up to date. Training was a mixture of online and face to face learning. Staff also completed training relevant to the needs of people using the service such as supporting people living with epilepsy, although we did note that staff did not currently have training in suicide prevention. One of the people using the service was known to express suicidal thoughts and had a self-harm risk assessments in place. We spoke with the manager and provider about this. We were advised that this training was currently being sourced and would be in place within three to six months. In the meantime, the management team were confident that staff would provide an appropriate and supportive response to any person expressing thoughts of self-harm.

New staff received a comprehensive induction which involved learning about the needs of people using the service and key policies and procedures. A support worker told us their induction had been very thorough and had included opportunities to shadow more experienced staff and learn about people's routines, risk management strategies and communication methods. The induction was in line with the Care Certificate which was introduced in April 2015. This sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

Staff told us they felt supported and that they received regular supervision. A staff member told us, "Its good to get things off your chest" whilst another said, "Yes I like a vent, sometimes everything builds up, you can chat about how you are doing". Most staff had had an annual appraisal. Appraisals help to ensure that the management team are able to assess the on-going competency of staff and support them with their career development.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration. Staff were able to tell us which people required a modified diet and which people had an allergy, although as indicated elsewhere in this report, we did find that this was not always followed in practice. Some information about people's food preferences and dietary requirements was displayed in the kitchen although this did not include the 'meal-time mat' or 'pacing advice sheet' provided by the speech and language therapy team for one person. Displaying this information can help to ensure that staff have quick access to person centred information which helps to ensure that people have an enjoyable and safe meal-time experience.

People were involved in decisions about what they ate. Menu meetings were held during which staff encouraged each person to choose their favoured meal from a set of photographs of a large range of meals. People were also involved in shopping for their food. We did note that staff were mainly responsible for cooking meals with little involvement from people. We spoke with the manager about this who agreed that

this was an area where improvements could be made. Records were maintained of what people ate and these showed that they were being supported to maintain a healthy and varied diet. We were told that people were weighed on a regular basis so that staff could be aware if people were losing weight, however we found two examples where there were gaps in people's weight records. One of these people was losing weight. We spoke with the manager who advised that staff would be reminded about the importance of recording people's weight and making appropriate referrals to healthcare professionals if needed. A relative told us, "They eat very well". Mealtimes appeared relaxed with some people eating together along with staff and others choosing to eat in their rooms. People were involved in clearing away after meals even if this was just by bringing their plate to the dishwasher.

Where necessary a range of healthcare professionals including GP's, community learning disability nurses, speech and language therapists and dentists had been involved in planning peoples support to ensure their health care needs were met. People had a health action plan which contained details of their medical appointments, the outcome of these and any required actions. Each person also had a hospital passport which was used to share key information with medical staff about the person's needs, their communication methods and behaviours in the case of admission to hospital. Staff told us that they were vigilant about people's health and quickly recognised if a person was becoming unwell. Records confirmed this with people being referred to their doctor when being short of breath or showing signs of a chest infection. A staff member said, "We generally know when [the person] is unwell, we are the first to get him down to the doctors and get antibiotics".

Good

Is the service caring?

Our findings

People told us they were supported by staff who were kind and caring. One person said, "They [the staff] are all nice people". Another person said, "I get on well with all the staff…yes they speak with me kindly". A relative told us the staff were "Always very pleasant". They told us their family member was "Happier [at Twynham] than anywhere they have been". A staff member told us the staff team were all kind and caring, they said, "Yes the staff are all kind, they help people to have a good day, otherwise they wouldn't be in the job". Another staff member said, "The team are all kind and caring, they are all softies". A social care professional told us staff were, "Very gracious in the way they speak with residents".

Staff knew and respected people's preferred daily routines. One person said, "I can do what I want" and another said, "They respect me, they have never stopped me going out". A social care professional had recently commented in the compliments book, 'I have been to visit two residents today, they have both reported being content and that they have active and varied lives and are able to influence some of what they do'. People were able to move freely around their home and garden and could choose whether to spend time in their rooms or in the communal areas. We observed a meeting during which people were encourage to share where they would like to go on holiday. People where able had signed their key worker and support session reports demonstrating they had been involved in giving feedback about what had worked well for them for that month.

The atmosphere within the home was calm and relaxing. People were supported to personalise their rooms as they wanted. Pottery work and pictures, some of which had been made by people using the service were displayed within the house to help create a homely environment. A relative told us, "It's very homely, it's a lovely place to be". Staff engaged people in meaningful conversations but were also seen to share a laugh or a joke with them when this was appropriate. Staff were also gently challenging when this was required, which helped to prevent people's anxieties from escalating.

Staff showed they had a good knowledge and understanding of the people they were supporting. Staff were able to give us examples of people's likes and dislikes which demonstrated that they knew them well. We were given examples of the types of food people liked to eat and what activities they enjoyed as well as their daily habits. This information was also reflected in people's care plans. Staff described how people communicated and people's care plans confirmed these communication techniques.

People were assigned key workers who worked closely with them so that they became familiar with their needs, likes, dislikes and preferences. They were also responsible for completing monthly evaluations and keeping family members informed about the person's progress. All of the relatives we spoke with told us they felt involved in their family members care. One relative said, "Yes we are kept informed…staff are so welcoming, even the new ones, they always speak with me, I get on with all of them". People were encouraged to maintain relationships with their family. Relatives were welcomed at the home or people were supported to visit them in their own home. Where people did not have close family or visitors we saw that staff had made referrals to formal advocacy services to ensure that people had every opportunity to express their choices and wishes. For example an advocate had visited one person to help them make

decisions about their dental care and about proposed changes to their medicines. Advocacy services help people to be involved in decisions about their lives, explore choices and options and speak out about issues that matter to them.

We saw evidence that staff were mindful of people's privacy and dignity. When people came to the office for their medicines, they were asked if they minded the inspector being present or would like some privacy. Staff told us how they ensured people had some privacy when being supported with personal care tasks by, for example, standing outside the bathroom whilst they were drying themselves.

People told us they felt respected. The provider had set up a service user committee involving people from different homes, although no-one from Twynham was as yet involved in this. The purpose of the committee was to give people an opportunity to give feedback about the care they received and to suggest improvements. One of the people using the service had been supported to be involved in training police officers on how they might understand and communicate better with people with learning disabilities. The manager told us that it was also important that people were encouraged to respect one another and we saw that this along with responsibilities and house rules had been discussed with people at a service user meeting.

Some people had easy read end of life care plans which had been drafted with the person, where able, and their relatives. We did note that these mainly recorded the person's wishes in relation the days following their death rather than describing how they would like their care and environment to be managed in their final days.

Requires Improvement

Is the service responsive?

Our findings

Whilst staff supported people in a kind, sensitive and respectful manner, we felt some aspects of how people's care was delivered in a generic manner. By generic, we mean care was delivered in the same way to each person and that some practices were out dated. For example, each person came to the office to receive their medicines. It was not clear to us that this arrangement was based upon people's individual needs. People were invited to come to the kitchen at 4pm to receive a piece of fruit. A staff member told us that a number of people had at their annual health checks been advised that they needed to watch their weight and so people were "not being given biscuits so much". They added that people could request snacks or drinks of their choice at any time but some of the people we spoke with did not seem to know this. A social care professional told us that whilst they felt things had improved in recent months they had at times felt the service to be "Restrictive and old fashioned".

We found evidence that suggested that aspects of people's care was not always designed and planned with a view to meeting their individual needs. For example, each person using the service had been assessed as potentially needing the same physical interventions. In some cases, the person did not display behaviours that would warrant, for example, a two person escort. Whilst no physical interventions had been used in the service for some time, we were concerned that this could increase the risk of interventions being used inappropriately. We spoke with the manager and provider about this. They advised that they had already identified this as area that needed to be reviewed and that action was being taken with the organisations behavioural support team to ensure that behavioural support plans appropriately reflected each person's individual behaviours and how staff should respond to these.

It was not always clear that some of the risk reduction measures that were in place were based upon the needs of people using the service or, were underpinned by a clear risk assessment, or had been agreed, following relevant mental capacity assessments to be in the person's best interests. For example, the kettle was locked away and the freezer containing puddings was locked. We reviewed four people's risk assessments in relation to their risk of scalding or burning themselves when using the kettle for example. In each case the risk had had been assessed as slight. The manager was not able to clearly identify why some of the restrictive practices were in place other than to reflect that it was possibly historic and based upon the needs of people using the service in the past.

It was not clear that the benefits of risk reduction measures were always balanced with people's rights to privacy or were reviewed on a regular basis to ensure the measures remained appropriate. For example, one person living with epilepsy had an audio monitor in their room which allowed staff to listen to their movements throughout the day and night. The original objective was that the monitor would alert staff should the person have a seizure. However, we noted that the person had not had a seizure in six years and had not been taking medicines for this condition for 15 months. However the appropriateness of continuing to use the monitor had not been reviewed. We were concerned that this was a potential invasion of the person's privacy.

Care and support was not always provided in a person centred manner. This is a breach of Regulation 9 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care.

Other aspects of people's support plans were more personalised and supported staff to deliver responsive care. Each person's support plan contained information about them as a person, their daily routines, how they communicated and what aspects of their behaviour might mean. For example, one person's plans described information about the signs that might indicate they were distressed and the behaviours they might then display. Information available included, how staff might help the person when anxious. Plans described, 'what people admire about me' and 'What is important to me'. For example, one person's support plan noted that people admired them for being 'friendly, cheerful and for having a good sense of humour'. Records were kept of people's special interests, but also the things they disliked. Care plans set out what people were able to do for themselves and the tasks with which they needed assistance. The support plans had been developed with input from the person's families and the health and social care professionals involved in their support. Staff told us they could refer to people's care plans in order to understand their needs and it was evident that the care plans had been read by staff.

The 'Living the Life' approach was used within the service. This is a tool that was developed for the provider and acts as a measure of whether people are achieving all that they want to in their life. The 'Living the Life' workbooks recorded people's learning and development goals, the relationships they might want to develop, the things the person really liked doing and how the person might make a contribution to the household and their relationships with the other people using the service. People's progress toward their goals and objectives was monitored at weekly meetings to help ensure that these remained relevant and meaningful. We did note that some people's goals could be more specific, for example, one person's goals were listed as 'access the community' and 'be more sociable'. In some cases there was no record that the weekly monitoring meetings had taken place in June 2016.

Staff completed detailed daily observation forms detailing what aspects of personal care had been completed and what activities they had taken part in. The forms included a record of any behaviours the person may have displayed and whether staff had needed to use any physical interventions to manage these. This meant that it was possible to effectively monitor aspects of the care and well-being of the people who were supported by the service.

Monthly key worker and support session reports were detailed and showed people's needs were being kept under review. More formal care reviews were generally held on an annual basis, and were an opportunity for the person, their relatives and relevant healthcare professionals to make their views known about the care provided by the service. The relatives we spoke with had confirmed they were involved in planning and reviewing their family members care.

The service had a member of staff who took the lead for supporting people with planning and accessing activities. People took part in a wide range of activities in line with their personal preferences. Within the home, people chose to do activities such as using the computer, listening to the radio and playing board games. The service had an activities room in the garden which had a range of games such as table tennis and table football. Some people had been involved in developing the homes garden and planting vegetables whilst others preferred to spend quite time in their rooms and enjoyed watching the TV or reading comics. The service had recently entered a garden competition which although they did not win had been enjoyed by people and staff. Outside of the home, people attended day services, bowling, boat trips and visited local cafes or beaches. One person particularly enjoyed one to one trips to a local shopping centre. People were supported to follow their particular interests, for example, one person had just finished a series of dance classes and would soon be started a keep fit class. People had also attended ceramics and woodwork classes provided by the local further education college. One person told us, "I'm going bowling

today, I like bowling, and food shopping this afternoon". People were supported to take breaks or holidays away from Twynham with staff support. One person had just returned from a break in Devon which staff said he had appeared to enjoy. Further breaks were being planned for the other people using the service. The manager explained that the organisation aimed to support people to be integrated into community life and to promote social relationships. One person was being supported to regularly visit their local pub and staff were supporting another person to develop their relationship with the local shop keepers they visited.

Complaints policies and procedures were in place and were available in easy read formats within the communal areas of the home. There had not been any complaints within the last 12 months, but people and their relatives told us they were confident they could raise concerns or complaints and that these would be dealt with. One person said, "If I was worried I would speak with staff and they would help me".

Requires Improvement

Is the service well-led?

Our findings

Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when the local authority approve an application to restrict a person's liberty to protect them from harm. Applications for a DoLS had been approved by the local authority for four of the seven people living at Twynham but the provider had not notified the Commission. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

The manager had only been appointed the week prior to our inspection, however they had previously worked within the service for a number of years and so were very familiar with people's needs. The provider ensured that they were supported throughout the inspection by their line manager. People clearly had a good relationship with the manager and felt at ease talking with him. One person said, "I don't have any complaints, if I did I would talk to [the manager] he would do something about it". Relatives told us they felt the service was well run and expressed regret that the registered manager had left, however they were also positive about the new manager. One relative said, "[the manager] seems to be managing very well". Staff told us the service was well led. One staff member said, "[the manager is a good leader, they are approachable, they know the guys, they work on the floor and will come and help. If we are short of night staff he will stay and over". Another staff member told us they were proud of the manager. They said "Everyone trusts him, will go to him, he will try and sort it". Staff told us that the manager operated an open door policy and was approachable and supportive. They told us they did not have to wait for supervision to discuss any difficulties or concerns they might have. We observed the manager had developed good relationships with each person which enabled them to be good role model to the staff team and promote the delivery of person centred care to people living in the home.

People, their relatives and staff were encouraged to give feedback about the service and this was used to drive improvements. An annual survey had been undertaken with people, relatives and the staff team. Overall the feedback was positive with 100% of people saying they felt safe at the service, could do the things they wanted and that their support was satisfactory. 100% of staff had said they received the training required to give a safe and effective service. The results had been analysed to help identify areas for improvement and these had been incorporated into a development plan which included the steps needed to deliver the improvements and a clear time scale for completion.

Meetings with people took place regularly and were used as an opportunity for people to make suggestions and to comment on how the service could be improved. We observed one meeting during which people were asked to make suggestions about the activities they wanted to do and where they would like to go on holiday. The meetings were also used to remind people how to raise a concern or complaint and to introduce or explain the provider's policies.
Staff meetings were also held on a regular basis. Issues discussed included policies and procedures and updates to people's risk assessments. Behaviour observation charts were reviewed and staff reminded about the importance of keeping people safe.

The provider had a range of policies and procedures in place to guide and support staff. These included guidance on sensitive issues such as the use of touch and physical contact when supporting people using the service. This policy acknowledged the importance where appropriate of the physical touch to people's emotional wellbeing and to convey concern for people. Staff were required to adhere to a set of 'Employment rules'. These included never mistreating a person, teasing or punishing them. It emphasised the importance of respect and of treating people kindly regardless of any behaviours they might display. Throughout our inspection, staff demonstrated that they worked in a manner that was consistent with these values and with the provider's policies and procedures.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving the best possible support. The provider supported people using their services to act as 'expert auditors'. An expert auditor from another of the provider's services had visited Twynham the week before our inspection and rated the service in a number of areas such as the environment, the menus and food and the activities. They spoke with people using the service and also asked staff questions. They had rated all the areas inspected as either excellent or good and had commented, "A wonderful run home and it was a pleasure to visit Twynham, the staff seemed well trained and knowledgeable in their work, fantastic, keep up the good work". Internal audits were undertaken by the area manager which reviewed a number of areas such as care plans, medicines, staffing, accidents and incidents, staff files, nutrition and hydration and the cleanliness of the environment. Each week, the manager submitted a report to the provider which documented whether people were taking part in the correct number of planned activities and whether they had had regular opportunities to access the community. Manager met with the managers of the providers other homes so that best practice could be shared and organisational issues discussed. Checks were made to identify any risks in relation to areas such as fire, gas and water safety. Checks were made to ensure electrical items were safe to use. The provider also had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home.

The manager was new in post and was yet to develop their vision for the service. They were however, aware of the challenges of taking on the manager role and the learning curve this would present. They told us that people using the service were their priority, but that they wanted to lead by example and be a good role model to the staff team. They expressed a wish to be open to new ideas and to doing things a different way where this was in the interests of people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Applications for a DoLS had been approved by the local authority for four of the seven people living at Twynham but the provider had not notified the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support was not always provided in a person centred manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were not always following risk management strategies.