

## Community Integrated Care

# Community Integrated Care (CIC) - 2 Seafarers Walk

### Inspection report

2 Seafarers Walk  
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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?

Good 

Is the service well-led?

Good 

# Summary of findings

## Overall summary

This inspection took place on 23 and 24 February 2016 and was unannounced.

2 Seafarers Walk is a service provided by Community Integrated Care and is situated in a quiet residential area to the south east of Hayling Island. The home is a bungalow which was purpose built to provide accommodation and care to five people with learning and physical disabilities. At the time of this inspection there were four people living in the service. There were sixteen permanent staff, which included two senior support workers. The service also used bank staff that were employed by the provider and were known to people living at the home.

There was no registered manager in post at the time of the inspection, however there was a service lead in post who was responsible for the day to day running of the service and had applied to become the registered manager. However the service lead was already registered with the commission in relation to the same regulated activity for a different location which is run by the provider. 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.

People were not always safe at the service. Interim measures were not always taken to ensure people and staff were safe from harm. There were concerns about the cleanliness of the home and the home was in a poor state of repair. Although people's day to day spending money was managed safely, people could be at risk of potential financial abuse and the appointees could be at risk of potential allegations of financial abuse because best interest decisions did not always include other appropriate professionals.

Staff knew how to keep people safe from harm and had a good understanding of how to report safeguarding concerns. Safeguarding concerns had not been raised since the last inspection.

Different types of risk assessments were in place for each person and risk management plans were implemented to ensure people and those around them were supported to stay safe. The service did not use restraint. Fire safety procedures were in place for the home and were followed to complete people safe.

There were sufficient staffing levels at the home, which was flexible to meet people's needs. Safe recruitment and medicine practices were followed.

Staff were experienced and knew people well. Staff received induction training in line with the Care Certificate when starting work at the home. Staff received regular supervision and one to one sessions.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA); however this was not always demonstrated when making best interest decisions for people who were deemed to lack capacity. We made a recommendation to refer to the Mental Capacity Act 2005 and its codes of practice. Staff demonstrated a

good understanding of the Deprivation of Liberty Safeguards (DoLS) and how to put this into practice.

People were supported to have enough to eat and drink and meal times were flexible to meet people's needs. People regularly accessed healthcare services.

The service was caring and people experienced care that was compassionate. Staff treated people as individuals and encouraged them to do as much for themselves as possible. People's privacy and dignity was respected.

People received the care and support they needed, were listened to and had their choices respected. A variety of communication techniques were used to ensure people were engaged with and involved in making decisions about the support they wanted. People's needs were regularly assessed and reviewed. Activities were personalised and meaningful.

People were given the information to tell them how to complain. Complaints had not been received about the service since the last inspection

There were clear visions and values in place and good leadership at the home. Quality audits were completed which supported the registered manager and senior managers to assess the overall quality of the home.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have also made a recommendation. 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.

The environment was not always safe. The home was in a poor state of repair. Repairs were reported but interim measures were not always taken to ensure people and staff were safe from harm. There were concerns about the cleanliness of the home and the quality of the cleaning, though these were addressed when pointed out.

Although staff knew how to keep people safe from harm and relatives felt people were safe. People could be at risk of potential financial abuse and the appointees could be at risk of potential allegations of financial abuse.

There were enough staff on shift to meet people's needs and keep them safe. Risk management plans were in place to manage people and risks. Safe recruitment practice and medicine procedures were in place.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005 (MCA).

Deprivation of Liberty Safeguards (DoLS) were in place.

Staff received regular supervisions and training. Staff knew people well and could demonstrate an understanding of people's needs and how they liked to be supported.

People were supported to have enough to eat and drink and have access to healthcare services.

### Is the service caring?

**Good** ●

The service was caring.

People experienced care that was caring and compassionate and staff treated people as individuals.

People were supported to express their views by making sounds, using facial expressions and body language. Staff knew people well and were able to identify what the person required when they made a certain sound or showed a certain type of facial expression.

People's rooms were personalised and staff respected people's privacy and dignity when completing personal care.

### Is the service responsive?

Good ●

The service was responsive.

People received the care and support they needed, were listened to and had their choices respected. A variety of communication techniques were used to ensure people were engaged with and involved in making decisions about the support they wanted.

People's needs were regularly assessed and reviewed and they, their relatives and other health care professionals were involved in the reviews and assessment of their needs.

Activities were personalised and people were supported to carry out the activities they enjoyed.

People were given the information to tell them how to complain. Complaints had not been received about the service since the last inspection

### Is the service well-led?

Good ●

The service was well-led

There was no registered manager in post however the service lead has managed the service since October 2015.

There were clear vision and values in place and a supportive culture. Staff confirmed management were good and they felt supported to raise any concerns about bad practice.

Quality audits were in place to ensure the on-going quality of the service was monitored.

# Community Integrated Care (CIC) - 2 Seafarers Walk

## **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 23 and 24 February 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed previous inspection reports, safeguarding records and other information received about the service. We checked if notifications had been sent to us by the service. A notification is information about important events which the provider is required to tell us about by law. We spoke with the Local Authority safeguarding teams and other external professionals who knew the service.

On the day of the inspection we spoke with four people who lived at the home. The four people we spoke with were not always able to share with us their experiences of life at the home; due to their disability. Therefore we also observed care practice to see how all four people interacted with staff. We spoke with two relatives, three support workers, two senior support workers and the service lead who was applying to become the registered manager.

We reviewed a range of records about people's care and how the service was managed which included the support plans for two people and specific records relating to people's health, choices and risk assessments. We looked at medicine records for two people, daily reports of support including staff handover communication notes, documents showing what activities people liked to do and had planned to do, menus, incident and safeguarding logs, complaints and compliments, health and safety records and minutes of staff meetings. We looked at recruitment, supervision and training records for three members of staff and service quality audits.

We asked the service lead to send us information on their policies and procedures after the visit. This information was sent.

# Is the service safe?

## Our findings

We observed people were happy and comfortable around staff and when they were being supported by staff. Relatives felt people were safe and treated as individuals. Relatives were encouraged to raise concerns about their relatives' care. One relative said, "Very safe. I've no concerns; we recently moved away and wouldn't have done that if we'd had any worries about [name]." Another told us they felt the service lead would listen to any concerns they had.

The environment was not always safe. On the first day of the inspection we observed the home to be in a bad state of repair in the communal areas, such as the washroom, kitchen, hallway, bathrooms and sleepover/sensory room. For example, the bathroom floors showed signs of wear and tear and discolouration around the bath and behind the toilet basin. This was similar in the washroom. Paintwork in the hallway, sleepover/sensory room, bathrooms, washrooms and kitchen was chipped and nine wall plugs were exposed in the sleepover/sensory room. Handrails in the hallways were marked and chipped, radiators were rusty and the doorways had large pieces of wood gouged out from them where people who required the use of a wheelchair had knocked into the doorways with their wheelchair. We spoke with the service lead and they confirmed they were aware of the need for the communal areas to be redecorated and this had been raised and reported through the appropriate processes. Records demonstrated this. However the service lead advised that the communal areas were not the responsibility of the provider and they had been experiencing difficulties with the organisation responsible.

Fixtures and fittings which required repair were reported but interim control measures were not always put into place to keep people safe from harm. We noted on the first day of inspection that a side panel had come loose and was protruding outwards to the right hand side of one of the radiators in the lounge; as a result there was access to the inside of the radiator where wires were exposed. We reported this to the service lead and this was reported immediately for repair. On the second day of the inspection the side panel was still protruding and interim measures had not been taken to assess and reduce the risk of potential injury or harm to people and staff. We spoke with the service lead who confirmed that they would look into this and put measures in place to reduce the risk.

The failure to do all that is reasonably practicable to mitigate risks and ensuring that premises used by the service provider are safe to use for their intended purpose and are used in a safe way is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control procedures were in place in the home and people were safe, however upon entering the property on the first day of the inspection we noted a smell of cigarette smoke in the hallway and found what appeared to be cigarette ash on top of the visitors signing in book in the hallway and on the floor in the kitchen. We spoke with the service lead who said they would address this with staff members. The home did not appear clean and furniture looked worn and tired. For example, there was a large rip on one of the sofas in the lounge, there were thick cobwebs under both radiators in the lounge, the cupboard underneath the television in the lounge was chipped and stained, food was present on the floor around the bottom of the oven in the kitchen and the kitchen, washroom and bathroom floors looked unclean. Staff and the service



lead confirmed the furniture was being replaced in April 2016, records confirmed this. Cleaning rotas were in place for the waking night staff to complete. We looked at the cleaning rota for the 21 and 22 February 2016 and noted that all tasks had been ticked as completed, including washing the floors and clearing away cobwebs. We spoke with the service lead who advised that they would address this with night staff. On the second day of the inspection we noted a clear improvement in the cleanliness of the home and the smell of cigarette smoke was not apparent.

Systems were not always in place to ensure that people's money was managed safely. The provider did not always follow their policies when carrying out best interest decisions regarding people's finances. We looked at three people's support plans and saw that mental capacity assessments dated September 2015 were present in all three people's records for the "Consent for contribution to the cost of staff meals whilst being supported in community on a one to one basis." As part of the best interest decision process we noted that external professionals and advocates had not been consulted. A best interest decision had been made only by staff working at the service; these were the service lead and two senior support workers who were the appointee for three people. An appointee is someone who has been formally chosen to manage monies on behalf of a person. The provider's staff meal policy dated 28 July 2015 stated, "Where a person supported is deemed to not have capacity then there must be an up to date mental capacity assessment in place, where the opinion of family and/or advocates are included in the Best Interest meeting which must be documented." The service lead dealt with this concern immediately and liaised with the local authority regarding this matter. This meant people could be at risk of potential financial abuse and the staff could be at risk of potential allegations of financial abuse. We recommend the provider refer to their staff meal policy dated 28 July 2015.

Safe practice was carried out when managing people's day to day spending money. People's money was kept in individual containers and in a locked safe. When people went out and took money with them it was counted out and back in to their individual container and checked each day by staff. We observed this practice being carried out.

Safeguarding concerns had not been raised since the last inspection and records and staff confirmed this. Staff knew how to keep people safe. Staff said they would keep people safe from harm by reporting any concerns to the service lead. This included recognising unexplained bruising and marks or a change in behaviour. Staff had received training in safeguarding adults and had a good knowledge of the procedures they should follow if they had a concern. The process for reporting a safeguarding concern was displayed in the office and all four members of staff knew where to find this information. For example, one member of staff said, "If I had concerns I would go to the [service lead] or the [senior support workers], I feel they would listen to me and act on it, if it were about the [service lead] I'd go to the regional management or I'd whistle blow, the number is in the office."

Risk assessments were completed for each person which identified risks to themselves and others. Risk assessments were in place for two people who required manual handling support from staff and staff had received manual handling training. Manual handling equipment had been recently serviced on 7 January 2016. Risk management plans were implemented to ensure people and those around them were supported to stay safe. For example, one person's risk management plan identified that the person had no fear of water and would be at risk of drowning if left alone in the bath. The risk management plan identified how staff should support this person to stay safe when using the bath. All staff knew how to support this person and confirmed what they needed to do to keep the person safe.

Risk assessments were in place for people who experienced behaviours that could be seen as challenging. All staff knew the signs and triggers to look for when a person experienced such behaviours. Staff were

confident they could manage the situation without the use of restraint. For example, one staff member told us one person could become agitated at times and they would manage to calm the situation by speaking calmly to the person and offering them a cup of tea or something to eat. They said they would also divert their attention by putting their favourite music on or giving them their favourite item to play with. The service leader and staff confirmed restraint was not used in the service as staff were trained in the Management of Actual or Potential Aggression (MAPA). This training would enable staff to safely disengage from situations that presented risks to themselves, the person or others without the use of restraint.

During our inspection we observed fire safety procedures were displayed in the hallway. Fire exits were clearly marked and the pathway was clear to access them. Fire doors were in situ throughout the home. All fire equipment had been tested regularly and in line with the provider's policy. We observed the fire alarm being tested during the inspection. There was a plan in place for a trained staff member to become a fire warden and would be the designated lead responsible for ensuring fire safety procedures were carried out safely. As a result of people's complex disabilities, fire drills, which included how to evacuate the building, were completed as a talk through simulation. A fire drill was completed on 26 February 2016. We observed that specialised manual handling equipment was in place for two people to be supported to exit the building in an emergency.

There were enough staff on shift. Relatives confirmed this. One said, "There always seems to be enough people at the home when I call. I've never had to search for someone." Staff told us there were enough staff on shift and shifts were very easy to cover because staff worked well together. One staff member said, "Staff are very flexible; we cover each other's shifts." The service lead confirmed three to four support workers worked each shift from 7.30am to 3pm and 2.30pm to 10pm, with an additional staff member working on the morning shift from 9am to 3pm. Staff confirmed this helped to ensure the rotas were flexible to support people on a one to one basis with their chosen activities and to take them to healthcare appointments. There were two staff who worked at the service overnight; one staff member completed an awake duty and another staff member completed the sleep duty.

There was a system in place to ensure there were enough staff at all times and the support was flexible to ensure people received the support they needed. The senior support workers were responsible for organising the staff rotas. The service lead and senior support workers confirmed they divided the total number of support hours for people by the amount of staff's contracted hours each week. Set activities were built into the rota which were reflective of the personal interests of people and there was flexibility for people to be supported with daily activities.

Safe recruitment practices were followed. We looked at three members of staff recruitment files and saw the appropriate steps had been taken to ensure staff were suitable to work with people. All necessary checks, such as Disclosure and Barring Service checks (DBS) and work references had been undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were clear procedures for supporting people with their medicines. Relatives confirmed they did not have any concerns with how the home managed people's medicines. The medicines were kept in a locked cupboard in people's rooms and only staff who had been trained and confirmed as competent by the service lead were able to support people with their medicines. Staff members demonstrated a good understanding of safe storage, administration, management, recording and disposing of medicines.

Checks were completed daily by staff who were trained to support people with their medicines. Weekly and daily medicine audits were also completed by the management team which included checking for gaps in

Medication Administration Record (MAR) sheets and any medicine errors. Both senior support workers and the service lead confirmed medicine errors had not happened in the service since the last inspection.

## Is the service effective?

### Our findings

Relatives were positive about the support people received. One relative said, "The staff know exactly what they are doing, a lot of them have been there a long time and those that haven't seek advice from their senior colleagues." Another relative told us they felt staff were very experienced and knew their relative well.

Staff confirmed they received an induction when starting work at the home. This induction programme included shadowing an experienced member of staff to watch and learn communication techniques and understand people's needs. Staff would also read people's support plans and take part in corporate induction training. New staff were subject to a three month probationary period in which their performance was reviewed at regular intervals. New starters had completed the Cavendish Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff had received regular supervision and one to one sessions which gave them the opportunity to discuss people and identify additional support for themselves. Staff were delegated responsibilities in line with their job description and abilities. They were given the opportunity to feedback on their performance and personal development. Staff confirmed they felt supported and could request any additional training that would help them meet the needs of people. The service lead had a training plan in place which identified when staff had completed training and when the training was due to be updated. The training plan also included details of staff who did not attend the training and the reason why and there were clear records to show that the training sessions had been rebooked and completed by staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA); however this was not always demonstrated when making best interest decisions for people who were deemed to lack capacity. For example, staff confirmed that people could consent to most decisions concerning their day to day support by using communication techniques individual to the person to help them make a decision. Mental capacity assessments had been completed when people were deemed to lack capacity and a decision needed to be made concerning a person's wellbeing or finances. However; best interest decisions did not always include the appropriate professionals, advocates and relatives. We recommend the provider refer to the Mental Capacity Act 2005 and its codes of practice.

We saw for two people a mental capacity assessment and best interests decision had been completed regarding the use of a lap strap on their wheelchairs when accessing the community for safety. We saw consideration had been given to whether the restriction was proportionate and the consequence of not having the restriction in place was highlighted. For example the person would be at increased risk of injury if the lap belt was not used. Consideration had been given to ensuring the restriction in place was not any more restrictive than was absolutely necessary as the mental capacity assessment and staff confirmed the lap belt was only to be used when the person was moving. This meant people were not restrained unlawfully and the provider followed the MCA 2005 and its code of practice, in this instance.

Staff demonstrated a good understanding of the Deprivation of Liberty Safeguards (DoLS) and put this into practice. We saw a DoLS authorisation form had been completed for four people due to the restrictions posed on them at night and when accessing the community. The staffing ratio was reduced to one sleep duty and one staff member who was awake. This placed a restriction on people between the hours of 10pm and 7am as they were unable to be supported in the community. All four people required to be supported in the community on a one to one basis and were unable to leave the service without support. A DoLS authorisation had also been completed for all four people for the use of seatbelts when travelling in the service vehicle.

People were supported to have enough to eat and drink. We observed a menu folder was in place which included Picture Exchange Communication (PEC) symbols and pictures of food items which rotated over a ten week period. People were supported to choose the food and drink of their choice and care plans demonstrated what food and drinks people liked and disliked. Drinks were offered and given regularly and when people requested drinks they were supported with this.

People were supported well at mealtimes. Two people were on a specialised diet because they were at risk of choking. Staff were aware of the people who required support with eating and confirmed that advice and guidance from a speech and language therapist (SALT) had been sought. Staff told us the SALT advised for one person's food to be pureed and another person was required to have their food cut into small pieces. We saw evidence of a referral to SALT had been made for these people and their support plans had been updated to include this information. We observed staff followed this guidance at people's meal times.

Staff and relatives confirmed people regularly accessed healthcare services. One relative said, "[Relative will always see a GP if he needs one and the home phone and tell me if [they] are poorly." We observed a person was being supported by a member of staff to attend an appointment on our first day of inspection. The visitors log showed regular visits from healthcare professionals such as a chiropodist and occupational therapist.

## Is the service caring?

### Our findings

Relatives were positive about the care and support received from staff. One relative said, "They are very kind and caring. I have no complaints whatsoever." Another relative told us that the care was perfect and that it was the person's home. When we asked people if they liked the staff who were supporting them they all smiled and some people made excitable sounds. We observed people felt comfortable with and around staff. People would often seek out staff and liked to be in or close to the area where staff were working. There was lots of laughter and positive interactions between staff and people.

We observed positive and caring interactions between members of staff and people. Staff spoke to people in a kind and respectful manner and people responded well to this interaction by smiling and responding verbally using words or excited sounds. One person would seek out a staff member and stand by the side of them on a regular basis. The staff member would acknowledge the person was there by smiling, speaking to them and gently rubbing their hair. Staff confirmed this person liked to have their hair touched and records confirmed this.

People were encouraged to do as much for themselves as possible. We saw people answer the door whilst being supported by a member of staff and welcome visitors into their home. Staff said this was the person's home and they were always asked if they would like to answer the door. Staff confirmed they always asked people what they wanted to do and would use different communication methods to support people to make a choice. People in the home were unable to communicate using clear words; however they could all communicate by making different sounds, using facial expressions and body language. Pictures were also used as a communication tool to ensure people were given the support to clearly communicate their needs and wishes. Staff knew people well and were able to identify what the person required when they made a certain sound, showed a certain type of facial expression or used a certain type of body language. One relative told us that some staff had worked at the service for a long time and their relative had "grown up" with these staff.

There was an effective system in place to request the support of an advocate to represent people's views and wishes. Where necessary referrals were made to advocacy services. Advocates had been involved in some best interests decisions for people. An advocate can help people express their needs and wishes, and weigh up and take decisions about the options available to them. They can help find services, make sure correct procedures are followed and challenge decisions made by councils or other organisations. The advocate is there to represent people's interests, which they can do by supporting people to speak, or by speaking on their behalf.

Staff confirmed they would respect people's dignity and privacy by closing doors, knocking before entering the person's room and informing them what they were going to do before supporting them with personal care or other support tasks. We heard staff knocking and asking if they could come in before entering a person's room and staff closed doors when they were supporting people with personal care. We observed one person being taken from the communal bathroom to their room and towels had been used to respect their dignity. We observed people were supported to keep clean and tidy. For example one person would

regularly spill their drink on their clothes and staff would change them regularly throughout the day. Relatives felt staff respected their relative's privacy and dignity.

People had individual rooms and these were decorated with the colour they liked. People's rooms were personalised with items such as photographs of their family and themselves on holiday and pictures of their favourite music groups or hobbies. For example, one person's room was decorated with lots of sparkly objects and a picture of Abba and another person's bedroom contained pictures and cuddly toys of turtles and the ocean.

## Is the service responsive?

### Our findings

People's needs were regularly assessed and reviewed by staff and people together. Relatives confirmed they had been involved in sharing lots of information about their relative's past history to help the home with planning care for people. Staff told us they had developed an understanding of people and their needs by supporting them over a period of time and as their key worker. A key worker is someone who is assigned to an individual and will work with them to build a care or support plan and develop an understanding of their needs and how the person can communicate their needs.

Staff knew about the people they were supporting. Staff gave us examples of how they supported people differently according to their needs. For example, one person loved water and enjoyed swimming and another person liked shopping trips and going for walks. A third person did not like to be touched; however they would allow an aromatherapist to give them a massage. As a result staff arranged for the aromatherapist to visit this person regularly. Records confirmed this. All people needed different levels of support with their personal care and staff demonstrated a good understanding of these needs.

All people had individual support folders which contained support plans and risk assessments. The support plans were very detailed and included people's likes and dislikes, personal histories such as when their condition was diagnosed, communication needs, behaviour signs and triggers, personal care support, health plans and activities they enjoyed. The service lead and staff confirmed families and other professionals were involved in gathering information about people. Regular observations of people's behaviours and interactions were used to develop the support plans and risk assessments over time. Reviews of care plans were completed. The service lead told us they had implemented a key worker role to include weekly and monthly duties which included reviewing people's support plans. Staff we spoke with confirmed this had been discussed with them and they were aware of the responsibility of this role.

One page profiles were in place in people's support plan folders to assist new staff or visitors to the home with accessible information to hand about people. This information included people's likes and dislikes; how they communicate and what was important to them. We saw in one person's support plan folder that a small booklet called, "This book is about me" was present and this had been put together by staff, the person and their relatives. The information contained within specified what the person liked to be called, what they liked and did not like, i.e. this person's booklet stated they did not like to be touched. The information in this booklet was up to date and gave the reader information in a timely manner about the person.

People were able to communicate by making sounds and noises or with facial expressions, using body language and pointing to pictures. Different communication techniques and tools were used with different people to encourage them to openly communicate their thoughts, feelings, likes and dislikes, choices and decisions. Communication books and handovers between shifts were used to communicate any information amongst staff about each person for that day, such as healthcare appointments, activities and additional requests for staff to review people's care plans and risk assessments.



Activities were personalised and people were supported to carry out the activities they enjoyed. Each person had an activities folder informing staff what activities they liked to do and what activities they had completed. For example, one person's activity folder demonstrated they liked swimming, going to the cinema and watching shows. Another person liked baking, being pampered by staff and going for walks. We observed this person having a pampering morning on the first day of our inspection and we observed photographs and other documents were present in these people's activities folders to demonstrate they had carried out the activity. Relatives confirmed that people took part in a lot of activities and one said, "[Relative] does get to go out a lot." We observed on the second day of the inspection that people took part in a group activity in the community with staff.

The service lead stated they were reviewing the current style of support plans as a new initiative called 'The Golden Thread' was being implemented in the service. The aim of the Golden Thread was to support the provider to become a "deeply person – centred organisation with the principles of personalisation sewn into the fabric of the organisation." The new support plans would introduce goal and outcome setting and support would be tailored to support people to take control of their lives and the support they received. Staff were aware of the new initiative.

Relatives confirmed they had never needed to make a complaint about the service. Staff confirmed complaints had not been received. Relatives felt confident to express concerns and if they had any issues they knew who to complain to and would be confident that the concern would be dealt with. One said, "If I had any complaints I'd talk to [staff name], I feel very comfortable talking to [them]." Another said, "I know how to [complain] but I've never had to." The service lead said they had not received any complaints since the last inspection. Records confirmed this.

We saw the complaints procedure was displayed in the hallway of the home and an easy read summary including pictures was also displayed showing people how they could make a complaint about their care.

## Is the service well-led?

### Our findings

There was not a registered manager at the home but a service lead was managing the home on a day to day basis and had submitted applications to register as the registered manager for the home.

There was a clear vision and a set of values that involved putting people first. The service lead said the organisation had rebranded last year and introduced a value statement which was, "People, Passion, Potential." The service lead said this also included respect, dignity and individual and personalised care. They said, "This is people's home and staff are aware that everything they did must be about the person." Staff were aware of the visions and values of the home and put these into practice when supporting people. Staff confirmed this was people's home. We observed these values being put into practice at the home during our inspection.

Staff described the culture of the home as, "One big happy family". One said, "Staff are very supportive." Another said, "Transparent and open." The service lead said they had an open door policy and were approachable to staff. Staff confirmed this and we observed that the office door was always open. Staff said management were very good and very supportive but they were concerned that the service lead was "spread too thin" as they managed three other homes for the provider. One said, "[Service lead] is really stretched between services." Another said, "[Service lead] is great but they are not here very often. We only see them once a week but it has been longer." However staff confirmed that the service lead was contactable and one told us the service lead was very good at their job and had "turned the place around." The service lead confirmed they felt three homes were manageable but they had recently been managing a fourth home. They confirmed a new service lead had been appointed to the fourth home which meant they would have more time to spend at each of their three homes. There were senior support staff in place who were being supported by the service lead to develop their skills and knowledge to enable them to support staff in the service lead's absence.

The service lead was supported by the provider's regional manager, who was not based at the home and there was an out of hours on call system run by the provider in place for both service lead and staff if they needed additional support.

Staff were supported to question practice and they demonstrated an understanding of what to do if they felt their concerns were not being listened to by management. One said, "Talk to [service lead] first to raise a concern and if nothing changed, I'd speak to the regional manager. There is a whistleblowing number on the wall." The service lead confirmed they would support and protect staff and people who raised concerns about other staff members.

There was a system in place to analyse, identify and learn from incidents and safeguarding referrals. Safeguarding concerns had not been raised since the last inspection. Members of staff told us they would report concerns to the service lead or out of hours regional managers and follow this up in writing. Management plans had been developed to help learn from incidents that had taken place and manage people's behaviour that may challenge others.

A number of audits had been completed to assess the quality of the home. Service Quality Assessment Tools (SQAT) had been completed by the service lead and were required to be completed annually. The service lead and regional director confirmed a new SQAT would be completed in March 2016. The SQAT helped identify areas of improvement for the service in the following areas; support planning, risk assessment, nutrition and healthcare, communication and decision making, health and safety, medication management, environment, safeguarding, leadership, staffing and training and quality and complaints. Once completed an action plan was developed highlighting the areas that required improving, who was responsible for implementing the improvements and the timescales. This information was then sent to the regional managers who would visit the location and sign of the SQAT once the action plan had been met.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The failure to do all that is reasonably practicable to mitigate risks and ensuring that premises used by the service provider are safe to use for their intended purpose and are used in a safe way. Regulation 12(2)(b),(d)</p>