Real Life Options

Real Life Options - 58 Ormesby Road

Inspection report

58 Ormesby Road
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Website: www.reallifeoptions.org

Date of inspection visit:
26 October 2015
10 November 2015
11 December 2015

Date of publication:
18 April 2016

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

This inspection took place on 26 October 2015, 10 November 2015 and 11 December 2015. The first day was unannounced which meant the staff and registered provider did not know we would be visiting. The registered provider knew we would be returning for the second and third day of inspection.

Fifty eight Ormesby Road is a large detached house situated in a residential area of Normanby which can provide accommodation for up to six people who live with a learning disability Care and support is provided to people on both floors of the service which can be accessed via stairs. At the time of our inspection there were five people living at the service.

The registered manager had been in place at the home for many years. 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.

We previously inspected 58 Ormesby Road on 9 February 2015. We found that checks of the emergency lighting for the service had been overdue and some policies such as quality assurance, Deprivation of Liberties Safeguards (DoL's) and health and safety had not been reviewed for some time. There were no records to show that applications to deprive a person of their liberty had been made or reasons for this decision making. Records such as training and recruitment, weight charts, key worker reports and cleanliness were not up to date.

At this inspection we could see that all staff were aware of safeguarding procedures and training was up to date. The service had dealt with safeguarding alerts appropriately. All staff told us they felt confident discussing any concerns they may have had.

Risk assessments were in place for people and had been reviewed. Risk assessments for the day to day running of the service had also been regularly reviewed. Certificates relating to the day to day running of the service were up to date.

Each person who used the service had detailed personal emergency evacuation plans in place. This meant people involved in the emergency situation could provide people with the most appropriate support.

There were enough staff on duty to provide care and support to people and staffing levels changed according to people's activities each day. People who used the service were involved in the interviews of potential staff members.

Medicines were managed appropriately. There were sufficient stocks of medicines in place for people. We highlighted some gaps in medicine records which were rectified during inspection.

People lived in an adapted house with bedrooms available on the ground and first floor. People had access to a variety of communal spaces on the ground floor and also had a large garden which they could access.

We could see that staff knew people well. Staff told us about people's likes and dislikes as well as their daily routines. People, their relatives and staff had good relationships with each other.
Each person who used the service had deprivation of liberties safeguards in place to keep them safe. Although people could not always make their own decisions, staff did try to involve them where possible. Staff always sought people's consent before any care and support was provided.

Staff told us that people's relatives were involved in making decisions about people because they had safeguards in place to protect them however the records did not always show this.

People's dignity and respect was maintained. People were not rushed when supported by staff and staff gave explanations when needed. Staff also supported people to access the local community and maintain relationships with the people important to them.

A complaints policy was available at the service. No complaints had been received at the service during 2015.

Meetings for people, their relatives and staff had been carried out and well attended. We found this allowed people and staff to be kept up to date of any changes occurring at the service.

Staff spoke positively about the registered manager. They had been in post at the service for many years. The registered manager was responsible for managing three services. We questioned the appropriateness of this because the demands of this outweighed the resources of the registered manager.

We found gaps in all the records we looked at during inspection. We also found that reviews were not always carried out in a timely manner.

Training, supervision and appraisal were up to date and where gaps had been identified we could see that dates had been planned in. Gaps relating to these records had been rectified during inspection.

People were involved in menu planning and were offered a varied selection of food and hydration. We saw that recommendations from one person's dietician on discharge had not been updated in the person's records.

People had regular access to health and social care professionals. Records of these appointments had not always been updated within people's records. This meant that we did not know if any changes had been recommended as a result of these appointments.

Accidents and incidents had been recorded, but there were gaps in these records.

Records relating to recruitment were not available for inspection.

We questioned the appropriateness of audits carried out at the service because they had not highlighted many of the gaps we found during our inspection. There were no records of any provider visits having been carried out at the service.

Following our inspection, we shared our concerns about the workload of the registered manager and the

standard of record keeping of the service with the local authority. We knew they had similar concerns and these are being addressed outside of this inspection process.

We found two breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the premises and equipment and records. 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.

There were gaps in accident and incident records. Information for audit purposes sent to the registered provider was not available for inspection.

Safeguarding alerts had been managed appropriately. Staff had good knowledge about abuse and the signs and symptoms which could be seen in people living with a learning disability.

Medicines were managed appropriately. Gaps identified during inspection were rectified.

Is the service effective?

Requires Improvement

The service was not always effective.

People saw health professionals regularly, however records did not always reflect this.

Training supervision and appraisals were up to date or had been planned in.

People were involved in menu planning and had access to a good range of nutrition and hydration.

Is the service caring?

Good

The service was caring.

People's dignity and respect were maintained whenever staff were providing care and support to people. People were not rushed.

People had choice about how to spend their time. People told us they enjoyed living at the service.

Staff spoke positively about the people they cared for. They knew people well and could tell us in detail about people's likes, dislikes and individual routines.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were significant gaps in all of the records which we looked at during inspection. There were gaps in the frequency of care reviews.

We asked the service to make improvements to the standard of record keeping at the service following our first day of inspection. When we returned we found that the service still needed to make further improvements.

People were involved in a variety of activities which were personal to them. People were supported to access these activities by staff.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager was responsible for managing three services. We found the demands placed upon them outweighed their resources.

Little action had been taken to address the concerns with record keeping at this inspection and following our last inspection in February 2015. At this inspection we identified breaches associated with records and quality assurance.

Staff spoke positively about the registered manager. Staff also told us they enjoyed working at the service and felt part of a team.

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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 26 October 2015, 10 November 2015 and 11 December 2015. One adult social care inspector was involved in this inspection.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service.

The registered provider was asked to complete 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.

During the inspection we spoke with three people who used the service. We also spoke with the area manager, registered manager, team co-ordinator and four staff. We observed care and support in communal areas of the home and reviewed two care records. We also looked at a range of records which related to the day to day running of the service. On the first day of inspection we asked the registered manager to make improvements to the standard of record keeping at the service. We returned on the second and third day of our inspection to look at what progress the service had made to improve the quality of record keeping.

Requires Improvement

Is the service safe?

Our findings

At this inspection we saw that risk assessments for the day to day running of the service were up to date and had been reviewed regularly. Each person using the service had specific risk assessments in place to minimise the risk of harm to them. We could see that people had risk assessments in place for things such as managing finances, utilities and correspondence, bathing, behaviour, abuse and rights. In one person's records, we could see that they had 21 risk assessments in place and in another person's records they had 19, many of which overlapped. We questioned whether this amount of risk assessments was appropriate; for example, these two people had risk assessments for staying safe, emotional abuse and physical abuse. We asked the registered manager to consider whether those three risks could have been considered in one risk assessment. For one person, risk assessments for walking, medicines, choking, door locks, bathing and communication hazards had not been identified.

A risk assessment for decision making stated that one person lacked the capacity to make important decisions and was therefore at risk of abuse. There was no information in this risk assessment to show what decisions were considered important. We could see from the record that family, staff and appropriate professionals should have been included in making decisions on the person's behalf, however action to control or reduce risks to the person were incomplete. A handling risk assessment for one person was originally completed in 2005; we could see that a new signature and date had been put in place at the bottom of the record for each year, including 2015. No new risk assessment record had been completed which meant that the signatures did not show if each of the prompts identified on the risk assessment had been considered each time the risk assessment had been carried out. The person had a risk assessment in place for choking, however key behaviours linked to this specific risk were not included in this risk assessment . This meant these risk assessments had not been completed appropriately.

This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A daily record was in place for staff to ensure the safety of the service. These daily checks included the security of the building, the cleanliness of the building and to check whether food was safe to eat for example. We looked at records between 1 and 31 October 2015, we found that there were 15 days where these records were incomplete. We could see that there service was clean, but we could not be sure if all of these activities had been completed by staff. We could see a note had been put in the communication book, however we could see that staff had not carried out this request.

This meant that there was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at accidents that had occurred at the service in September and October 2015. From the accident records, we could see that one person who used the service had experienced a small number of falls however these had not been recorded on the person's falls record. This meant the service had been unable to carry out an analysis of the falls to identify ways of reducing the risk of harm to this person. An accident

dated on 24 September 2015 had been documented; however, there were no details of what investigation was carried out to minimise the risk of a further accident. No action plan had been put in place and the record had not been signed by the staff member completing it. A staff member had been involved in an incident dated on 17 September 2015. We could see that the incident record was incomplete. This meant that we did not know if the staff member had been able to continue with their work following this incident. Records relating to notifications, investigations and actions within this accident record had not been completed and there was no signature of the staff member completing the record. The registered manager told us that an accident audit was completed each month and sent to their head office, however no analysis or feedback from these reports where available at the service throughout our inspection.

We were not able to look at records relating to recruitment (application forms and contracts, for example) because they were kept at head office and were not available on any days of our inspection. A summary staff record of recruitment was kept at the service for three staff, which we looked at. This included a picture of the person and detailed qualifications and previous experience in care. We could see references had been checked but could also see gaps throughout the staff records which included photographs and employment history. There were also gaps where the service manager was required to sign which had not been completed. We could see that each member had a Disclosure and Barring Service check carried out prior to employment. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

We looked at how the service managed medicines. Each medicine administration record included a photograph of the person the record related to. Information about how to take each medicine was included, for example, one person took one medicine from a spoon with a glass of water. There were sufficient stocks of medicines available for people. One person was prescribed a controlled medicine. Controlled drugs are medicines that are liable to abuse. The record detailed why and when this medicine should be given. This medicine required the signature of two staff members to ensure this medicine was given appropriately. On two occasions we could see that two signatures were not in place. We spoke to one staff member about one occasion and they told us that they had forgotten to get a second signature on the occasion it related to. On two separate occasions there were two signatures; however, there was no record about how much of this controlled medicine was given to the person. This meant that we did not know if this controlled medicine had been given as prescribed.

Guidance for 'as and when' (PRN) needed medicines was in place for the three people's records looked at. However, we found they had not been reviewed every six months as directed in the guidance. We asked the registered manager to take action to review all of the PRN guidance and on the third day of our inspection found that this had been done. One person was prescribed a PRN medicine which was not recorded on the MAR chart; the team leader on duty took action straight away. Medicines audits had been regularly carried out, however we questioned the effectiveness of them because they had not highlighted a missing signature for a controlled drug and had not found that a medicine was missing from the MAR. An up to date medicine policy was in place. Room temperature records had been recorded each day. This meant that procedures were in place to ensure medicines were stored at a safe temperature.

We looked at the medicine competencies of five staff who were trained to dispense medicines. The registered manager told us that staff were assessed each year. We saw that four staff had been assessed, however one staff member had not been assessed since June 2014. The medicines competency assessment record was signed and dated at the bottom of the previous sheet, a new record had not been completed. This meant that it was not clear how or what specific competencies relating to medicines had been

assessed.

Safeguarding alerts had been made when needed to the local authority and the Care Quality Commission had been notified by the service. Safeguarding records included detailed information about incidents which had led to alerts being made, the action taken to reduce the risk of harm and the outcome of the safeguarding alert. From the notifications we received and from speaking with the registered manager we could see that investigations had been carried out and actions identified, however safeguarding records did not always reflect this. All staff spoken with during the inspection demonstrated a good understanding of safeguarding and when and why an alert should be made. The team co-ordinator told us that examples of potential safeguarding alerts could include, "Name calling, pushing people and medication errors." We were aware that not everyone living at the service could speak out and we asked staff what might make them aware that people were experiencing abuse. One staff member told us, "People here are non-verbal so it would be hard for them to say. I would look for physical signs such as bruising or observe for changes in their behaviour. But I would always report this to my manager." Staff training in safeguarding was up to date. All staff told us they felt confident to whistle blow [tell someone] if they needed to. The registered manager told us they did not carry out restraint on people; staff had training in de-escalation techniques which they used only when needed. The team co-ordinator told us they helped to keep people safe by, "Keeping doors locked and adhering to people's care plans and risk assessments. All staff are required to do this." This meant the service had procedures in place to minimise the risk of abuse occurring.

Certificates for equipment, such as wheelchairs and for the day to day running of the service, such as gas and electric were up to date. Checks of the fire alarm had been carried out every month and the last test of a fire evacuation showed that staff responded quickly.

Each person who used the service had a personal emergency evacuation plan (PEEP) in place. Each PEEP showed what awareness each person would have in the event of an emergency and what help they would need. For example, in two people's records we could see that both people would ignore the alarm and would require staff to alert them and guide them to the exit. Records showed where people required assistance because they were unsteady on their feet or because the noise could cause distress. All staff spoken with during the inspection told us they felt confident dealing with a medical emergency. One staff member told us, "I would ring 999. I am trained in basic first aid and would carry out chest compressions and mouth to mouth if I needed to."

There were enough staff on duty to provide care and support to people. During each day of our inspection we could see that staffing levels changed depending upon the activities taking place. One staff member told us, "We always have enough staff, we have been short on occasion, however this has only been when sickness was very short notice." The registered manager told us that people who used the service participated in the interview process of potential staff. They told us that people meet with potential staff in a group setting and have coffee. This is an opportunity for the interview panel to observe how the potential staff member communicates and behaves around people living with a learning disability and for people to give their feedback. This is good practice when recruiting new staff.

Requires Improvement

Is the service effective?

Our findings

All staff undertook an induction at the start of their employment with the service. New staff spent time shadowing more experienced members of staff to help them get to know the people they would be supporting. One staff member told us, "I was supervised when I first started whilst I got to know people." This also meant that staff could familiarise themselves with the routines in place which were important to the people using the service. Staff were regularly monitored during their induction and were supported with understanding policies and procedures relating to the service and with training. We looked at the induction record of one staff member and there was no record of the day they started work at the service. Included in this record were a list of twelve activities which included things such as reading policies and understanding people's routines as well as what action to take in the event of a fire. Each of these activities needed to be completed and signed by the staff member and the registered manager and then determine whether the staff member was competent in each area. Of the 12 activities, none had been signed by the staff member and 11 had been signed off by the registered manager. The staff member had not been signed off as 'competent' in any of the 12 activities and had not been signed off as competent to support people. We could see that this person was working at the service but the records did not show if they were competent to do so. When we spoke with the registered manager we could see that the staff member was competent and they had been a failure to complete the records appropriately. In another staff members induction records, the first, second and third month probationary meetings with the staff member had been signed by the manager but not the staff member. The fourth months meeting had not been completed and on the fifth month the record showed the manager was required to make recommendations to determine whether the probation period was complete; this had not been completed.

We looked at the supervision and appraisal records of ten staff. These are formal processes to support staff to perform well in their roles. All ten staff had received between four and six supervision sessions during the last year. Only six staff had received appraisals and four were overdue. We could see that planned dates for appraisals for these staff members had been put in place. We found significant gaps in supervision and appraisal records. For example, two members of staff's appraisal records did not record whether the previous year's objectives had been met; there were gaps relating to training and development, staff member and manager comments and a managers signature. In the supervision records, we found gaps in supervision agenda, health and safety and personal development sections for all records looked at.

One person had received their influenza vaccination in line with medical advice from the person's GP. This person did not have capacity to consent to such as decision and there was no information in the care records about a best interest's decision having being made for this. The registered manager told us that there had been a historical agreement between staff and each person's family for influenza vaccinations. We could see that staff had acted in people's best interests; however records did not reflect this.

People who used the service had hospital passports in place. These included a photograph of the person the record related to. The hospital passport included 'red alerts' which were things 'you must know about me' such as personal details, prescribed medicines and allergies. 'Amber alerts' described things which were 'important to me' such as how to communication with the person, assistance with personal care and

sleeping habits. 'Green alerts' described the things the person's likes and dislikes. There was no information in one person's record about the person's routines. Routines are important for people living with a learning disability as any disruption to routine can cause distress. Providing this information in the hospital passport could assist hospital staff to help maintain the person's routines and reduce any distress. In another person's records, there were no details about how to communicate with the person. When we spoke to a staff member about this, they told us, "Communication is trial and error with this person. If they like it, they will clap their hands for example. When they want something, such as a drink they take for a drink. If you give them milk they will push you away; if you give water they will take it from you." This information was not recorded anywhere which meant anyone who did not know the person would not know how to support them effectively.

These were breaches of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not always work effectively with external professionals to maintain and promote people's health and wellbeing. One person had been discharged from the speech and language therapy team in June 2014. The discharge letter gave details about warning signs for choking when eating or drinking and food should be given in bite sized chunks. The letter also stated that staff should keep a record of food likes and dislikes along with ways of modifying foods and the person should sit upright at a table for food and drinks. The team co-ordinator told us, "Stringy foods presented as a choking hazard for this person." There was no mention of this in the care records or risk assessment. The team co-ordinator told us that staff would not be aware of the recommendations put in place by the speech and language therapy team. This meant the service had not followed the guidance given by health professionals and had failed to update the care records to reflect these recommendations.

Another person's care records which we looked at showed that their annual health check and medicines review were due in July 2015, however there was no record of these being carried out. Staff at the service could not confirm if these reviews had been carried out. We could see that this person had attended appointments with their GP (though not in July 2015) but records of these appointments did not show if an annual health check or medicines review had been carried out. We could see that this person had attended appointments with their dentist and podiatrist.

Each person had a health action plan in place. This record detailed when health checks were due, such as the dentist or optician for example. We could see from the records that a six monthly review should have been carried out; this had not been done for one person and a prompt on the record to ask whether the plan reflected the person's needs was incomplete. This meant the health action plan was not up to date. From the person's care records, we could see they had received regular support from their GP; this information had not been updated in the person's health action plan. We could see that a quarterly health audit had been completed in October 2015. Another person's records showed that they had attended their GP for a review of their medicines in April 2015, however records did not show any evidence of what the review entailed or what the recommendations following this medicines review were. This person also attended for an annual health check on the same date but again there was no record of any recommendations or details of this review. On the third day of our inspection, we could see that this person was overdue for their dental appointment. We could see an entry in the person's notes which stated "Waiting for them to ring back," there was no date of this entry which meant we did not know when action had been taken. On this day of our inspection, the team co-ordinator told us that this person had not seen their dentist and the service had not taken action for to make an appointment for this person.

This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014

At the time of our inspection, there were 23 staff employed at the service. We looked at the training records for all staff. We could see that training was up to date for most staff. This included health and safety, the Mental Capacity Act, Safeguarding, First Aid and Food Safety, for example. Where gaps had been identified, staff had been booked onto training.

A four-week menu was in place at the service and people were involved in developing them. This meant people could have their choices included. One staff member told us, "People eat well. There is a four-week rolling menu. If people don't eat it, we take it off the menu." On some days, there appeared to be a lack of choice available for people, however one staff member told us, "People make a choice by rejecting food. If people are still hungry following their meal they will stay sitting at the table. We will then offer something else." People were supported with their diet and hydration. The team co-ordinator told us, "[A person] is choosy with food; they have lost weight and need lots of encouragement. They have been seen by a dietician and their dietary intake is connected to their behaviours." At the time of our inspection, we were told that no-one required to be monitored with their nutrition or hydration, however should someone become at risk of this risk assessments and fluid and food balance charts were put in place. The service made referrals for more appropriate support when needed.

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

At the time of our inspection, there were 6 people who had a DoLs restriction in place. The team co-ordinator told us that one person had a safeguard in place because "[The person] wouldn't be safe outside on their own. They would fall over and they have no road safety, they don't recognise danger and would dash into the road without regard." Records show the dates of which decisions were made and applications granted. Records also showed the reasons for the decisions to put a restriction in place and the people involved in the decision making. We could see that restrictions had been put in place to minimise the risk of harm to people. One staff member told us, "When people can't make decisions for themselves, they can have the support of families and advocates. Safeguards are put in place to support the service user from anything untoward."

People who used the service lived in an adapted house. There were bedrooms on the ground and first floor of the building which were accessed by stairs. People could spend time in a variety of rooms on the ground floor and had access to a large garden. When people had visitors, there were private spaces available for them. There was also parking available for visitors. During our inspection, work was on-going to improve the service and to keep up with the maintenance of the property.

Good

Is the service caring?

Our findings

An up to date privacy and dignity policy was in place. From reading this policy, we could see that staff were following this policy. We could see that staff knocked on people's doors and waited for permission before entering people's rooms. The team co-ordinator told us, "We follow people's care plans, close doors and encourage people to do things for themselves."

The team co-ordinator told us, "Staff have been here a long time and know people well. They have close relationships with people and their families." Staff treated people with kindness and compassion and we could see that staff cared for the people they supported and their needs always came first. We knew this because staff were able to tell us about people, from their personal histories, likes and dislikes to the meanings of the communication there were displaying for example, hand gestures). One staff member told us, "[The person] would rock if they were not happy." Another staff member told us, "Communication with people is trial and error at times. If [The person] likes it, they will clap their hands." When we asked three people living at the service they all give their approval by smiling, nodding their head and giving their thumbs up.

We could see that staff listened carefully to people to make sure they fully understood what the person was saying. One staff member told us, "All of our service users are individual and have their own personalities." Staff worked to people's individual routines, they told us routine was important to people and helped to minimise any distress. The team coordinator told us, "[The person] likes routines, it's important. Any change can be very stressful for them – it can really throw them. We have to change one thing at a time." One staff member told us, "When we run a bath for [the person], we take the items into the bathroom before involving them. [The person] then shows their preference for these items by touching them." From speaking with staff, we understood how this specific routine was important to the person; it also demonstrated that staff followed people's wishes whilst allowing people to have choice. On each day of our inspection we could see that each person had been supported with their personal care and were appropriately dressed before leaving the service to participate in activities.

Throughout our visit we saw staff obtaining people's permission before any care and support was given. We saw that staff always took the time to speak to people when they entered a room. We could see that people could receive support when they wanted it. Staff assisted people to maintain their own rooms, cook, clean and do laundry. We saw that staff prompted people to carry out the tasks needed rather than to do things for them. This helped to maintain their independence.

Any conversations about people were carried out in private, for example, when making appointments on the telephone or when health professionals visited the service. When we looked at the records of people's care reviews, we could see that people's relatives had been happy with the care and support their relative had been receiving and had been involved in making decisions about people's care. Although people didn't have capacity to make specific decisions, we could see that staff always tried to involve people in decisions about their day. We saw that staff gave people explanations, for example, on the first day of our inspection, we saw that one person had a visitor from a health professional and staff told this person about the reason

for this; on the second day of our inspection, staff asked one person what they would like to do on that day and choices were given based on the person's preferences.

People were involved in any changes occurring at the service. For example, everyone at the service had been involved in discussions about changing the décor in the living room. On the first day of our inspection, we could see that wallpaper and paint samples had been put on the wall to allow people to make a decision. Later, we saw that the changes to the décor had been made using the majority vote. The three people we spoke to told us they were happy with the changes made.

There was information about advocacy displayed at the service. This is specific independent support to ensure people are treated with dignity and respect and have appropriate support to make choices and decisions about their own lives. An advocate can help people to have their voice heard and listened to so that they have control over their own life.

At the time of our assessment, there was no-one using the service who was receiving end of life care, however each person had a document in place to make sure their wishes were adhered to when the time came. This record included information about the things which are important to the person, any songs, prayers or wishes which should be recognised and any wishes of the person's family. In the records of one person looked at this information had not been completed.

Requires Improvement

Is the service responsive?

Our findings

Records did not consistency record people's needs and preferences. We looked at two care records in detail. Each had a variety of needs assessment and support plan in place, but we found gaps throughout these records. Records were not always signed or dated by the people their related to or by people acting in their best interests. Two people had needs assessment in place to be healthy which included personal hygiene, behaviour, diet and exercise for example. The accompanying support plans stated each person should be support to attend health appointments but they did not state what support was needed with the areas identified in the needs assessment.

Monthly reviews were carried out with people which reviewed activities each person had been involved in, what they thought was working, what needed improving and how the person was involved. We looked at records between May and December 2015 and found that there were three months when these reviews were not completed for one person. Records for another person were only available for July and October 2015; there were two consultation records in place for this person in October 2015. We found gaps in these records, for example, we could see that the health and finances sections (including risk assessments) had not been completed. There were no signatures of the person completing the records and there was no information about the people involved in these consultations. There was guidance available along with these records which detailed how the consultation document should be completed. We looked at this guidance and found these records had not been completed in line with this guidance.

Yearly person-centred reviews were carried out to review all aspects of each person's care. The person, their relatives, staff from the service and health professionals were invited to be part of this reviews. This meant that people involved in specific aspects of the person's care could be included in planning care or making recommendations. For one person, we could see that they had not had this type of review since January 2014.

One person was unable to communicate with us. When we looked in this person's care records there was no information about how to communicate with this person using more specialised communication techniques. From our observations, we could see that staff communicated with this person using hand gestures; however there was no evidence of this in the person's care records. This meant that we did not know the meaning of the hand gestures used.

In one person's records, we could see that daily records related to activities the person had been involved in, the food they had consumed and their mood. From speaking with staff we could see that this was because this person required increased monitoring in this area. For another person, we found daily records were not person-centred, for example in a record dated 30 October 2015 there was no information on this day about the person's mood or health. On 31 October 2015, daily records stated the person was "unsettled," but no further information provided or details about what staff did to improve how the person was feelings. On 1 November 2015 the daily record stated "[The person] sat chilling in the chair" On 2 November 2015 the record stated [The person] sat in the lounge snoozing" and on 5 November 2015 the daily record between the hours of 10:00 and 16:00 stated "Centre." From speaking with staff, we were able to determine that this

person was attending a day centre during this time however there was no information written in the daily notes about the person's time there.

One person was at risk of falls and we could see that they had been documented and accident forms completed however as part of their behaviour they also fell from the sofa to the floor in a controlled manner. The team co-ordinator told us that falls determined to be behaviour were not recorded. We could see that a review of falls had not been carried out to determine how to reduced risk of falls and how to improve the behaviour of the person deliberately allowing themselves to fall which could increase the risk of harm to the person.

There was guidance available to complete staff handover records and included things such as discussing incidents, staffing as well as people who used the service and completion of the handover of keys for the service. We could see that prior to November 2015, records had been completed appropriately. However records looked at between 1 and 5 November 2015 confirmed this not to be the case. These records had been written in a notebook and the team co-ordinator told us this was because the service had run out of paper. The service had a communication book in place which was a way of informing staff about changes at the service or updates which they needed to be aware of. We could see that regular entries were made and staff were required to read and sign each entry. When we looked at these records between 1 September and 1 December 2015, we could see staff did not regularly sign to say they had read these entries. This meant we did not know if staff were aware of changes and updates relating to the service.

People living at the service had support from their families, from the staff at the service and from a range of health and social care professionals such as social workers, learning disability nurses and their GP. We could see that where appropriate some of these people had been involved in making decisions about the person. However records had not always been signed by people or their relatives. The registered manager told us that they always sought relative's permission with care plans however records did not reflect this. On the second day of our inspection, a 'Methodology statement' dated 6 November 2015 had been put in place. This record stated that the person did not have capacity to be involved in decision making about care and the person's parent had signed to say they were happy with the care plan.

After the first day of our inspection, we discussed our concerns about the quality of record keeping at the service and asked the registered manager to take action to improve the records. We told the registered manager that we would come back to look at what improvements had been made. On our second day of inspection, we could see that an action plan had been put in place for training, records and supervision. We could see that the registered provider arranged for a member of administrative staff to spend time at the service; we saw that they had put the staff files in order. This meant all records relating to recruitment, induction, training, supervision and appraisals had been filed appropriately, however gaps in the records remained. On the third day of inspection we could see that sufficient action had not been taken to improve the standard of record keeping across the service. In all of the records we looked at during this inspection, we identified gaps throughout the records; these records related to people's care records, recruitment, supervision and appraisal, audits, handover records and health and safety records for example.

This meant that there was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had a one page profile which provided quick information about how to support them, what was important to them and what people would say about them. This is useful information when supporting someone new and can provide useful prompts about topics of conversation for example. We asked the registered manager to include information about the person's dislikes too and this was done.

A daily needs assessment for one person provided very detailed information about the person's routine, for example, we could see what care and support this person required and at what time. The record included information about what encouragement the person needed to get out of bed, the temperature of the bath water and what items would be required and where to place them.

We saw that people regularly accessed the community to participate in a range of activities. From one person's records, we could see that they regularly went shopping, to the local pub to eat and attended a local tea dance as well as trips out to the park. The team co-ordinator told us about the activities one person was involved in. They said, "Activities with [the person] are important to them. It has been trial and error over the years." We could see that people were free to do what they wanted at the service. Staff told us that this was people's home and they should be allowed to what they wanted when they wanted. People living at the services had all of the choices which we expected them to. This included when to go to bed and when to get up, what to wear and when they wanted to go out. We also saw that staff worked with people to live their lives in the community and were supported to access the local shops and eat out in the community. People were supported to attend activities with family and friends and groups specifically for people living with a learning disability. This meant staff encouraged people to maintain relationships with the people important to them. When families visited the service, they were given the space and privacy needed. We could see that staff, people and their families knew each other well.

A complaints policy and procedure was in place, however the registered manager told us that no complaints had been received during the 2015 last year. Staff were aware of the action they needed to follow should they receive a complaint.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in February 2015 we issued a requirement notice in relation to record keeping because we identified gaps in all records looked at; this includes care records, cleaning records and records related to the day to day running of the service. During this inspection we spoke to the registered manager about our concerns in relation to record keeping. Many of the areas in relation to record keeping identified throughout this report were also highlighted at our previously inspection in February 2015. This meant that there is a continued breach of records. We also talked to the registered manager about the appropriateness of managing three services because it was clear during inspection that the demands of running the three services were outweighing the resources they had in place. We knew that the local authority had similar concerns about these and following inspection we shared our concerns about this and record keeping with them. These concerns are being addressed outside of this inspection process.

The registered manager had been in post at the service for many years. Staff spoke positively about their professional relationship with the registered manager and felt able to approach them when they needed support or had any questions or concerns. All staff who we spoke with during our inspection spoke positively about working with one another. Staff told us they felt each person was approachable and could be relied on at all times.

At the time of our inspection, the registered manager was responsible for managing three services and they spent two and half days per week at 58 Ormesby Road. There appeared to be little support in place for the registered manager which meant that they did not have time to keep on top of all aspects of managing the service. We could not see if the registered provider had recognised the impact of managing three services was having upon the registered manager and the day to day running of the service. We could see that staff at the service were not carrying out the duties expected of them in relation to records. This meant that we were not sure if staff knew what was expected of them in relation to record keeping as we could see that staff had not received training in relation to record keeping. One staff member told us, "The records need improving." The team co-ordinator told us, "Progress has been made [with the records], but not enough. We need to become tougher with the staff." We could see that people were well cared for and this was the priority of the registered manager and their team. Shortly before our inspection, a member of care staff had been promoted to care coordinator to support the registered manager at this and their other services.

At the time of our inspection no records were available of the provider's visits to the service to monitor the quality of the service. We requested this information following inspection however it was not available.

No copy of the survey given to people was available which meant we could not be sure if it had been given in a format which was suitable for people living with a learning disability. The results of the 2014 survey were given to us during inspection. These were not in a format suitable for people living with a learning disability. This meant that we could not be sure if the results had been discussed with people. We queried the suitability of some questions, for example, one question asked "Do you have a one page profile?" We were not sure if someone living with a learning disability would understand what this meant. There was no action plan in place following the results of this survey. This meant that we did not know if the service had acted

upon feedback. We could see that a service user satisfaction survey had been planned for October 2015, however this was not available during our inspection.

Infection prevention and control, medicine, and care plan audits had been carried out regularly, however they failed to highlight any gaps in record keeping identified during our inspection. We did not see any evidence of audits specifically in relation to record keeping. A weekly health and safety audit was in place. Records looked at between 18 July 2015 and 22 October 2015 showed that this weekly audit had been missed for eight weeks during this timeframe. A monthly health and safety audit was in place at the time of our inspection, however, from the records we could see that it had only been carried out in April, September and October 2015. We found significant gaps in the records of these audits, for example, information relating to training, lone working, risk assessments, checks of the building and signatures were missing in each of the audits. We spoke to the registered manager about this and they told us that this monthly audit was no longer in use. We looked at the new health and safety audit dated 12/10/15 and found that the date of the review had not been completed, the date of the last electrical system check was incomplete and it had not been signed by the area manager.

This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with the registered manager and staff, we could see they enjoyed working at the service. One staff member told us, "I find working here very rewarding. It's nice to see people smile, giggly and happy." The team co-ordinator told us, "The people who live here is the best thing [about working at the service] for me. The team is good and I love supporting them."

The service had acted appropriately when carrying out investigations in safeguarding alerts, accidents and incidents. They had notified the local authority and had worked with them when needed. They had notified the commission when appropriate to do so.

Regular staff meetings were carried out and well attended by staff. We saw that agendas were sent to staff prior to meetings. During meetings, updates from the managers meetings were discussed as well as quality assurance, safeguarding and health and safety. There was evidence of one meeting for people and their relatives during the last year. We could see that confidentiality; bullying, menus and decoration had been discussed. We could see that an action plan had been developed from this. The registered manager told us that feedback from people and their relatives was sought generally and through person-centred reviews.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not been completed appropriately; people had not received timely healthcare appointments and guidance from health professionals was not updated in care records or followed. Regulation 12 (1).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were gaps throughout the care records and records relating to the day to day running of the service. Audits did not highlight the concerns we found during inspection and no registered provider audits had been completed. The service had not taken the action needed to address this breach at the last inspection.

The enforcement action we took:

A warning noticed was issued.