Creative Care (East Midlands) Limited

Sternhill Paddock

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Sternhill Paddock on 24 July and 2 August 2017. The inspection was unannounced. The home is situated in the small village of Eakring, Nottinghamshire and is operated by Creative Care (East Midlands) Limited. The service is registered to provide accommodation for a maximum of six people with a learning disability. There were four people living at the home on the days of our inspection visit. This was the first time we had inspected the service since they registered with us.

During this inspection we found multiple breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

The service had a registered manager in place at the time of our inspection. 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.

During this inspection we found that people were not always protected from risks associated with their care and support. Staff did not always follow guidance in care plans and incidents were not thoroughly reviewed to prevent the risk of repeat events. Although people's relatives told us they felt their relations were safe, appropriate action was not always taken to ensure that people were protected from the risk of abuse and improper treatment. People were not supported by staff who had been safely recruited. People's medicines were not always stored or managed safely, although immediate action was taken to address this.

We were not assured that people would be protected from the use of prolonged physical interventions and records relating to physical inventions required improvement to ensure people were supported safely and effectively.

Staff received an induction when starting work at the service and felt supported in their role. On the whole, staff had access to training to meet people's needs. Improvements were underway to ensure that staff received training in a timely manner. We found that there were not always enough staff available to meet people's needs and ensure their safety. Swift action was taken to increase staffing levels following our feedback.

The principles and application of the Mental Capacity Act were understood by staff and where people lacked capacity to make decisions for themselves their rights were protected. People had enough to eat and drink and were provided with assistance as required, however improvements were required to ensure that people were supported to maintain a healthy diet. People's day to day health care needs were met and people had access to support from specialist health professionals. There was a risk that people may not receive appropriate support with specific health conditions, although action was underway to improve this.

People were given choices about their care and support and staff acted upon this to ensure that support was based on their individual needs and wishes. People had access to advocacy services to help them express their views if needed. Staff understood how people communicated and people were supported to maintain their independence. Staff understood the importance of treating people with kindness, dignity and respect and we observed this in practice. Staff also respected people's right to privacy.

Staff had a good understanding of how to support people. There were care plans in place detailing the care people needed, although these required some improvement to ensure they were clear and easy to use. People spent their time doing things that they enjoyed and this was based on their individual interests. They had the opportunity to get involved in activities in the home and the local community. People knew how to complain and complaints were documented, investigated and action was taken to address concerns raised.

We identified some shortfalls in the way the service was monitored. There were not sufficiently robust or comprehensive governance systems in place to ensure people were provided with safe and effective care that met their needs. Appropriate action was not taken to investigate incidents which posed a risk to the health and wellbeing of people who used the service. The provider and registered manager were responsive to feedback and took swift action address the areas of concern raised at this inspection.

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.

Appropriate steps to ensure that people were protected from the risk of abuse and improper treatment were not always taken.

People were not always protected from risks associated with their care and support. Safe recruitment practices were not always followed.

There were not always enough, adequately trained staff to provide care and support to people when they needed it. Swift action was taken to address this.

Medicines were not always stored or managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Physical interventions were not always managed to ensure that people were supported in in the least restrictive way possible. People's rights under the Mental Capacity Act (2005) were respected.

On the whole, staff received training and support to enable them carry out their duties effectively and meet people's individual needs. Staff were provided with regular supervision and support.

People were supported to have enough to eat and drink; improvements were required to supporting people to maintain a healthy weight.

People's day to day health needs were met. There was a risk that people may not receive appropriate support with specific health conditions, although action was underway to improve this.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with

respect. People's rights to privacy and dignity were promoted.

People were provided with information in a way that was accessible to them and staff had a good understanding of how people communicated.

People were enabled to have control over their lives and were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Where possible people and their families were involved in planning their care and support.

People were supported to have a social life and to pursue their interests and goals.

People were supported to raise issues and staff knew how to deal with concerns if they were raised.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and improve the quality and safety of the service were not always effective.

Appropriate action was not taken to analyse and investigate incidents which posed a risk to the health and wellbeing of people who used the service.

Staff felt supported and were able to express their views in relation to how the service was run.

The management team were responsive to feedback and took swift action address the areas of concern raised at this inspection.

Sternhill Paddock

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, to look at concerns we received about the service and to provide a rating for the service under the Care Act 2014.

We inspected the service on 24 July and 2 August 2017. The inspection was unannounced. The inspection team consisted of two inspectors and a specialist advisor who was an expert in services for people with learning disabilities.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit we spoke with one person who used the service, we also contacted the relatives of three people who used the service. Some people who used the service were not able to provide feedback on the service they received, due to the way they communicated and so we also carried out general observations of care and support also looked at the interactions between staff and people who used the service.

We spoke with three members of care staff, the registered manager and the provider's quality and compliance manager. After our inspection visits we spoke with the nominated individual. The nominated individual is a person who is nominated by the provider to represent the organisation.

To help us assess how people's care needs were being met we reviewed all or part of three people's care records and other information, for example their risk assessments. We also looked the medicines records of all four people, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

All of the relatives of people living at Sternhill Paddock told us that they felt their loved ones were safe. One relative told us, "(Relative is) one hundred percent safe. Totally confident." Despite this we found that some improvements were required to ensure that people were protected from harm.

Although staff and managers had a good knowledge of the principles of safeguarding adults and were aware of what action to take should they have concerns, appropriate action had not always been taken to ensure people were protected from the risk of abuse or improper treatment. We found that a number of unexplained injuries had not been investigated and consequently referrals had not been made to the local authority for consideration under their safeguarding adult's protocols. We saw records in the care plan of one person which showed they sustained unexplained injuries on two occasions. These had not been followed up to ascertain how the injuries had been sustained, or if a referral needed to be made to the local authority. Records for another person showed that they had sustained skin damage on two occasions. Again no action had been taken to alert the manager to this and consequently it had not been investigated and no referral had been made to the local authority. This meant that incidents may not be fully investigated to ensure people were protected from the risk of harm or abuse. Additionally this resulted in a lack of learning to minimise the risk of these injuries and skin damage occurring again in the future.

This failure to take action to ensure that people were protected from the risk of abuse or improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the above concerns with the registered manager who told us they took immediate action to review all relevant records. Following our visit they informed us that concerns had now been investigated and where appropriate the local authority had been notified. They also told us that they had implemented new processes to review some records to identify the need for further action to ensure people's safety.

People were not always protected from risks associated with their care and support as guidance in care plans was not always followed. There was a risk of serious injury to one person, who demonstrated self-injurious behaviours. There were a number of discrepancies between what was directed in the positive behaviour support plans and what staff told us about how they supported the person. For example, one person was at risk of injury through self- harm and the care plan was inconsistent with what staff told us they did to prevent this person sustaining an injury. The approach taken by staff was not recorded in the positive behaviour support plan and the risks of this approach had not been assessed. Furthermore, records showed multiple occasions where this person had sustained injuries resulting from their behaviour, some requiring hospital treatment. We were not assured that everything possible had been done to prevent serious injury through self-harm. The team leader told us that they were awaiting advice from external specialist professionals, but in the meantime, the approach to protecting the person from the risk of harm had not been thoroughly considered and documented. Following our inspection visit the registered manager provided an action plan, which detailed action planned or underway to reduce the likelihood of injury to the person. This included seeking further advice from specialist professionals and purchasing additional aids

and equipment.

Records of incidents and documents such as body maps were not effectively reviewed which may mean that opportunities to prevent future incidents could be missed. For example, we reviewed two body maps both of which recorded that a person sustained markings to their skin resulting from physical intervention. These body maps had not been reviewed by the registered manager, which meant they were not aware of this information and consequently this had not been investigated to ensure staff had used physical intervention in a safe and appropriate way. The same person's care plan stated that a specialist seatbelt clip must be used when they were travelling in the car to ensure they did not endanger themselves or others. However a recent incident record documented that the person took off their own seatbelt, implying that the seatbelt clip was not in use. This incident record had not been adequately reviewed and consequently there was no evidence of any action having been taken to address this issue. This absence of analysis of records meant that opportunities to reduce the likelihood of further adverse incidents may be missed.

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

Adequate steps had not been taken to ensure people were protected from staff that may not be fit and safe to support them as safe recruitment processes were not always followed. Where staff had cautions or convictions, a risk assessment should be completed to assess if the staff member is suitable to support people who use the service. We found this was not being carried out in a robust way. We discussed this with the manager who took steps to address this, however this still did not result in a robust risk assessment. In another staff file, we found that there were no written references in place from previous employment. There was a note made of a verbal reference but this was brief and did not include verification of the dates the staff member was employed. This meant that the provider did not always have all the relevant information to make a decision about the suitability of the staff members employed.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found other risks associated with the service or people's care and support were managed effectively. Thorough risk assessments and care plans contained individualised information about how to keep people safe. These described how any risks should be managed and this was balanced with promoting people's independence. For example one person regularly went swimming and there was a risk assessment with control measures detailing how the person should be supported to keep them safe. People's personal money was managed safely to reduce the risk of financial abuse. Risks associated with the environment were assessed and managed safely. This included risks relating to the internal environment such as scalding from hot water or preparing meals. Where risks were identified there were measures in place to minimise the risk of harm.

The relatives of people living at Sternhill Paddock told us that they felt that there were enough staff to ensure people's safety. One relative told us, "There are enough staff. They have complex people there and they do a fantastic job with them." Despite this, during our inspection visit we found that staffing levels were not always sufficient to ensure that support was provided safely.

There were not always sufficient numbers of staff available to carry out physical intervention in a safe way. Physical intervention is a method of responding to challenging behaviour which involves different methods of direct physical force to limit or restrict a person's movement.
Staff told us and records showed that one person frequently required physical intervention performed by

four members of staff. However there were not always four members of staff available to support this person. Records of a recent incident showed that there were only three staff available to provide support which meant staff were not able to perform the required physical intervention safely. This put the person at risk of harm.

Staff told us that night staffing levels were normally sufficient but may not be adequate should an incident occur during the night. We asked staff what would happen if there was an incident overnight and they told us that they would call the on call manager who would then provide advice and potentially attend the service, within 30 minutes, if required. This did not assure us that the on call system would provide responsive, timely support in the event of a crisis or emergency situation. We discussed our concerns about staffing levels with the registered manager and following our inspection visit they took swift action to increase day time staffing levels and to arrange a 'contingency' member of night staff. This was confirmed by staff on the second day of our inspection visit who described this as being "much better."

Despite positive feedback about the management of medicines from the relatives of people who used the service, during our inspection visit we found several concerns in this area. There was a risk that people's medicines may not be effective as staff and managers were not always knowledgeable about the safe administration of medicines. For example one person was prescribed a medicine which stated that it must not be taken at the same time as indigestion remedies. However, this medicine was prescribed to be taken at the same time as an 'as required' indigestion remedy. Although records showed that these medicines had not administered at the same time there was a risk and this could have had a potential impact on the effectiveness of the medicine. We raised this with the registered manager and team leader who were not aware of the warning and told us they assumed that GP's checked the warnings.

Medicines were not always stored or managed safely. For example, we found a bottle of liquid medicine where the pharmacy label had worn away. This meant it was not possible to determine what the medicine was, or, who it was intended for. This posed a risk that the medicine may not be administered as required or administered to the wrong person. We also found a medicine which had been removed from its original container, staff had written a label for the new container, but, this did not have details of the dosage and it had not been signed by the staff member or witnessed by another staff member. This lack of information increased the risk of error.

Medicines records were not always fully or accurately completed to ensure the safe administration of medicines. For example, one person was prescribed a variable dose medicine (e.g. 'take one or two tablets') staff did not record the actual amount of medicine administered. This meant it was not possible to determine how much medicine the person had taken. We discussed our concerns about the administration of medicines with the registered manager. They took immediate action to address the issues we raised and to access specialist support, to ensure the safe administration of medicines.

We observed that, as far as possible, people were encouraged and supported by staff to play a role in managing their own medicines. For example we observed a team leader taking the time to support a person to measure out their own medicines whilst ensuring they did this safely. Where people were prescribed medicines on an 'as required basis' protocols were in place to guide staff on when to administer these and this was referenced in the people's care plans. Where 'as required' sedative medication was used frequently the registered manager had been proactive in exploring alternatives.

Requires Improvement

Is the service effective?

Our findings

We were not assured that people would be protected from the use of prolonged physical interventions. There was evidence of frequent use of supine restraint (where a person is restrained on the floor, face up) for one individual. Incident records did not always contain sufficiently detailed accounts of the period of restraint. For example, one incident record stated that the person had been restrained in supine position for a period of 40 minutes. Although the record stated that staff 'dis-engaged and re-engaged' from the intervention every five minutes it did not provide a description of the person's behaviour throughout this period to evidence that restraint for this length of time was required or being used as a last resort. This meant that we could not be assured that restraint was used for the shortest period of time possible. Following our inspection the registered manager told us that staff would be required to attend additional training to ensure accurate records were kept of any physical intervention.

Guidance for staff about physical interventions was not always clear which meant there was a risk of inappropriate techniques being used. For example one person's positive behaviour plan, for when the person's behaviour reached 'crisis point' stated that particular types of physical intervention may be used. However, this did not include detail of how many staff should be involved or specify the scenarios in which the different physical interventions should be used. This meant there was a risk that a consistent approach may not be taken by staff. Following our inspection visit the provider informed us that information about which interventions to use when had been detailed in care plans. We will check this at our next inspection.

Records showed that, on most occasions, staff were effective in using de-escalation techniques to reduce the need for physical interventions. However, we found evidence that in some instances staff actions may have unintentionally escalated situations and led to the use of physical intervention. For example, we reviewed an incident record in which a person who was having a shower had sprayed shower gel at a staff member. The staff member removed the shower gel, rather than finding an alternative way of managing the situation, for example moving away from the direct area. The removal of the shower gel resulted in the person becoming very agitated, and this ultimately led to staff using physical intervention to restrain the person. This means the person may have been subjected to unnecessarily restrictive practices. Following our inspection visit the registered manager told us that action had been taken to ensure staff had clear guidance about how to support the person in the shower to avoid causing agitation and distress.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received information of concern that physical interventions were not always used as a last resort. During this inspection we did not find any evidence to support this concern. The relatives of people living at the home were positive about the approach staff took to managing people's behaviours. The relative of one person told us, "(I have) no concerns about (physical intervention). They have changed routines and timing for things like brushing their teeth when [name] is resistant to them (to avoid distress)." Another relative told us, "If there is a meltdown staff rally round and deal with it well."

Without exception staff told us that physical intervention was only used as a last resort. One member of staff talked about a particular person and said, "I would gladly take [person] for a ten mile walk rather than restrain them". Staff described being listened to and encouraged to try out new ideas to avoid the use of physical intervention, such as exploring aids and equipment to meet people's varying sensory needs and making adaptations to people's routines and the environment. The provider worked closely with the local multi-agency challenging behaviour team (ICATT - Intensive Community Assessment and Treatment Team). We saw records of regular meetings and evidence that advice was sought regarding positive behaviour support. We spoke with a specialist health professional who praised the resilience and tenacity of the staff team and felt that they were proactive in exploring alternatives to physical intervention.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. People were supported by staff who had a good understanding of the MCA. Both staff and managers had a good working of knowledge about their duties under the MCA and how to support people with decision making. People's support plans contained clear information about whether people had the capacity to make their own decisions. We saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed.

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. The registered manager had made applications for DoLS where appropriate and some of these had been granted. The registered manager was aware of specific conditions imposed upon people's DoLS authorisations and had taken action to ensure that these were met.

People's relatives were positive about the food at Sternhill Paddock. The relative of one person told us, "The menus are very good, set up for the week ahead. They get them involved in cooking and it is all home cooked and healthy." Staff and the registered manager told us that people were involved in making choices about the weekly menus and this was displayed in a pictorial format. Staff told us that people were give choices at meal times but could also request something different and we saw this in practice throughout our inspection visit.

Some improvements were required to how people were supported with nutrition. For example, although one person was at risk of losing weight, food records were not always fully completed and showed that on some days the person was only offered small, basic snacks at meal times. We saw evidence that this had been identified by the registered manager who had requested that staff ensure the person was provided with adequate portions of food. However we saw that this continued to be an issue. Another person had difficulty maintaining a healthy weight and needed to be supported to eat a healthy diet. We reviewed food records and found little evidence to show that the person was being assisted to make healthy choices and records showed they had gained weight in the previous two months. We shared this feedback with the registered manager and following our visit they informed us that nutrition care plans had been updated and nutrition and healthy eating would be discussed at a forthcoming staff meeting to ensure people's needs were met.

The relatives of people living at Sternhill Paddock told us that they felt that staff were competent and skilled. One relative told us, "They seem to have the training," and went on to tell us that they had provided training to the staff team on their relation's specific needs. Another relative commented, "Yes (staff are competent), and where a deficiency is found, they are very quick to ensure any skills gap is closed." Staff we spoke with felt there was enough training given and if they requested additional training this was sourced. For example one member of staff had recently asked for training on Makaton (a form of simplified sign language) and the registered manager was sourcing this. Training records showed that staff had completed training identified as compulsory by the provider. This included; safeguarding, moving and handling, equality and diversity and first aid.

Although all staff were trained in advanced level of physical intervention at the time of our inspection training records showed that there had been delays of up to four months in some new staff accessing training to enable them to undertake safe physical interventions. This had resulted in some shifts where there were not enough staff trained in the advanced level of physical intervention to ensure safe support. For example a recent incident record showed that it had been necessary, to prevent injury to the person, to use a staff member without the required level of training to perform the restraint. Although no injury was sustained by the person on this occasion this delay in training resulted in a lack of appropriately skilled and trained staff placed people at risk of receiving inappropriate or unsafe support. The registered manager and provider told us that plans were in place to address any gaps in staff training and ensure that staff had timely access to training in the future.

New staff were provided with an induction period when starting work at the service. The registered manager told us that staff induction included training and shadowing of more experienced staff. New staff were also in the process of completing the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support. Staff told us that they felt supported and records showed they had received regular supervision and appraisal of their work. Staff were offered a debrief following adverse incidents and staff told us these were a useful form of support after potentially stressful events.

People were supported with their day to day healthcare needs. People were given support to attend regular appointments and to get their health checked. People had their healthcare detailed in their care plan and in addition, each person had a health action plan specifying support they required with their health. The relative of one person who used the service told us, "We always receive any details of medical problems and doctor's visits." Staff sought advice from external professionals when people's health and support needs changed. Records showed that referrals were made to external physical and mental health specialist teams when advice and support was needed. We saw the advice received was included in people's support plans and acted on. When people had specific health conditions we identified that care plans did not always contain adequate detail in order for staff to provide effective support. We shared this with the registered manager on the first day of our visit and on the second day of our inspection visit we saw that improvements were underway.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring in their approach and this was reflected in the feedback from the relatives of people who used the service. One relative told us, "They (staff) are very nice and polite, enthusiastic, a lot of energy." Another relative used words including "friendly" and "approachable" to describe the staff team.

We observed very positive, friendly relationships had developed between staff and people who used the service. A relative told us, "(Relation) is always happy to go back. They are very welcomed, everyone gives them a hug like they are one of the family. [Relation] thrives off this as they are very tactile." Another relative commented, "Staff clearly care very much for [relation], and [relation] is clearly fond of them."

Staff treated people with respect and knew people well. We observed that people who used the service appeared to enjoy the company of staff and were comfortable in their presence. People living at the home had care plans that contained information about what was important to them, such as the way they liked to spend their time, things that other people liked and admired about them and details of important relationships they had with friends and family. These were written in a person centred way and parts were written in a way that people who used the service could understand. This meant staff had information what was important to people they supported.

Two people's relative's commented that the approach of the staff team had a positive impact on people's anxiety levels and consequent behaviour. One relative told us, "[Relation] used to do a lot of self-harming and has not done this much so I can tell they are happy with their life." Another relative commented, "It's been very positive for us from the day [relation] went there. [Relation] is so much calmer. We got the right place the first time." We observed that staff responded quickly and appropriately when people became anxious or upset. For example when one person became very anxious, causing them to make loud vocalisations, staff remained calm and provided reassurance and support until the person calmed. Staff spoke with compassion, insight and empathy about the acute anxieties people experienced and the impact of the use of physical interventions.

Staff had a good understanding of people's sensory support needs. Staff we spoke with had an insight into the sensory sensitivities experienced by people who have autism and had developed ways to enable people to express and manage this. For example one person got comfort from pressure on their skin, and throughout our inspection visit we observed staff using weighed clothing to help calm the person.

People were involved in decisions about their support. People's relatives confirmed that their relations were involved in making choices about their care. One relative told us, "[Relation] has choices on their planner and if they want to do something then it is added to the planner. [Relation] goes shopping and chooses their own clothes." Another relative told us, "I believe they use picture cards where [relation] is given a choice of activities or snacks etcetera." During our visit we saw that people were, as far as possible, involved in decision making and staff routinely checked with them about their preferences. Staff met regularly with each person who used the service to discuss their care and support. Records of these meetings showed that

these were used to assess if people were happy with the support they were receiving, to see what had worked well for the person and what could be improved. There were also goals set for the next three months, six months and year.

Staff and the management team had a good understanding of people's communication needs and tailored their support accordingly. There was information in people's support plans about how people communicated and how staff should communicate with them and staff demonstrated a good understanding of this throughout our visit. For example, one person's care plan stated they used signs to help them understand, and be in control of their routine. During our inspection we saw staff using this approach to explain what they would be doing next, thus reducing the person's anxiety. People were provided with information in a format that was accessible to them. We saw that information was provided in a variety of formats including signs, symbols and photos. Pictorial timetables had been developed to help people plan their time and reduce their anxiety and staff had developed accessible prompts and signs for people, based upon their individual needs.

People had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. The registered manager told us that one person was using an independent advocate to support them to make decisions. We also observed that there was information about advocacy displayed in the service in a format that was accessible to people who used the service.

People were provided with support to maintain and develop their independence. Care plans contained clear details of areas where people needed support, areas of things they could do for themselves and also identified goals to maximise people's independence. People who used the service had access to the kitchen and were assisted to prepare meals, snacks and drinks throughout our visit. People were also encouraged to maintain and develop daily living skills such as shopping, cleaning and other household tasks. These were detailed in people's care plans and activity plans with details of what encouragement and support people would need with the skills.

Staff respected people's right to privacy and promoted their dignity and this was reflected in the comments of people's relatives. The relative of one person told us, "Yes (staff do respect relation's privacy)." They went on to describe a recent event where staff had acted swiftly to preserve the person's dignity. We observed that people's privacy was respected throughout our inspection visit. Staff knocked on people's doors before entering and prompted people to attend to their own care needs as required. People were supported to spend time alone if they wished, staff had a good understanding of how to ensure people were safe whilst respecting their privacy. Staff respected people's right to confidentiality. Conversations about people's support needs were held in areas that could not be overheard and care records were stored securely.

Good

Is the service responsive?

Our findings

Each person who used the service had an individual care plan. People who used the service were not able to be actively involved in the development of their care plans but it was clear from the person centred nature of the care plans that these had been developed based upon learning of what was important to each person and how best to support them. Where possible the relatives of people who used the service had been developing their care plans. The relative of one person told us, "(I) had discussions with staff about what [relation] likes and what help they need. They have got to know [relation] and what routines they like." Another person's relative described how the registered manager sat with them and developed their relative's care plan.

Care plans were detailed and personalised. Plans contained clear information about the person's level of independence as well as details of areas where support from staff was required. Plans were reviewed regularly by the staff team and the majority of information contained in plans was up to date. Staff we spoke with told us that they were given time to read and contribute to people's plans and demonstrated a good knowledge of people's preferences and support needs. We found that some care plans did not give clear guidance for staff on how to support the person as information was spread across multiple sections of the care plan and was difficult to locate. For example, it was recorded in one person's nutrition plan that the person might ask for a hug but this might also mean they were hungry and wanted a snack. This had not been recorded in the person's plan for how they communicated and so there was a risk staff may not understand what the person was trying to communicate. We shared this feedback with the registered manager who told us that care plans would be reviewed to ensure important information was easily accessible to staff.

People spent their time doing things that they enjoyed and which were based on their individual interests and passions. The relatives of people who used the service told us that they felt that people had enough to do with their time. One relative told us, "Absolutely fantastic. Absolutely brilliant. They (staff) Get [relation] doing stuff that I couldn't. [Relation's] social experience has improved." Another relative told us, "[Relation] goes to weekly disco, swimming, out every day to country parks and places of interest."

There was a variety of personalised activities on offer within the service and we observed that everyone who used the service also went out in to the community on the day of our visit. Care plans contained information about people's hobbies and interests and we saw these were included in the daily activity plans in place and that staff supported them to undertake the activity. For example, the records of one person stated they liked to go swimming. This was planned into their activity schedule for the day we inspected and we observed staff supported the person to go swimming. The activity plans also included social activities such as visits to country parks, walking, a local disco, the cinema and in-house activities such as baking and video games. It was clear that staff saw social activity as part of their role and we observed that when staff had spare time they sat and talked to people and encouraged people to get involved with activities.

People were supported to maintain relationships with their family and friends. For example, one person regularly went to stay with their family at the weekends and went on holidays with them. People were given

the opportunity to discuss contact with their family at regular meetings with staff and were given reminders and prompts about things such as sending birthday cards.

People's relatives knew how to raise concerns or complaints and felt confident to do so. The relative of one person told us, "No problem whatsoever (in raising concerns), (I) would approach the staff or [registered manager]." Another relative told us, "They are addressing things and have corrected any issues. They are taking things I tell them on board and implement what I say."

There was a complaints procedure on display in the service and this was presented in an easy to read format. Systems were in place to ensure that complaints were responded to in a timely manner. Records showed that complaints had been documented, investigated and responded to appropriately. For example, a member of the local community had raised some concerns and records of staff meeting showed that these concerns had been discussed with the staff team. Staff we spoke with were aware of their role in recording any concerns received and communicating these to the management team. This meant the provider had a system to ensure complaints were appropriately managed.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place at the time of our inspection visit. The systems in place for the registered manager and the registered provider to monitor and improve the quality of the service were not always comprehensive or effective. For example, we reviewed recent medicines audits undertaken by staff and found that the issues identified during our inspection were not found at any of these audits. For example, we found that warning on medicines were not being followed, this had not been identified in recent audits. We also found that the medicines audit was being conducted by staff who did not have sufficient knowledge to ensure the effectiveness of the audit and consequently issues were not identified. For example, although the audit prompted the auditor to look at completion of medicines records, recent audits had not identified that staff were not using coding on medicines records as intended. This resulted in people being placed at risk, as there were insufficient systems in place to ensure the safe management of medicines.

Systems in place to review and analyse incidents and other significant documentation, such as body maps, were not always effective. This had resulted in a failure to identify, investigate and address concerning information. For example, we reviewed an incident record which documented that there had not been enough staff available to perform physical intervention safely and in addition recorded that it had been necessary to deploy a member of staff who did not have all the necessary training. This document had not been effectively reviewed and consequently these issues had not been identified or addressed. We also identified that body maps were not routinely reviewed and found a number of these documented unexplained injuries sustained by people which had not been investigated. This failure to thoroughly review and analyse key records meant that incidents had not been properly investigated and opportunities to identify ways of preventing future incidents had been missed. This exposed people to the unnecessary risk of potential harm and injury.

Furthermore the failure to review and analyse incident records meant that learning from incidents was not consistently used to inform, update and improve care plans and practice. Incident records for one person showed that staff practice was not always in line with recommendations in positive behaviour support plans. Staff we spoke with told us that the approaches documented in the positive behaviour support plan did not always work, so they had developed alternative approaches to ensure the person's safety. There was no evidence that due consideration had been given to the safety of these alternative approaches and the person's positive behaviour support plan had not been updated to reflect these changes. This failure to have effective systems in place to monitor and improve the quality and safety of the service meant people were at risk of unsafe support.

The provider did not have sufficient systems in place to monitor and oversee the quality and safety of the service. The provider relied on feedback from external agencies to inform quality assurance and improvement at the service and this had resulted in a failure to identify and address issues relating to the quality and safety of the service. The registered manager informed us that, although the Director of Operations did "informal quality checks", no formal quality assurance visits by the provider, had taken place since the service opened. This meant that issues such as the failure to investigate unexplained injuries,

unsafe recruitment practices and insufficient record keeping had not been identified. This absence of formal governance and quality assurance processes meant that the provider had not identified and consequently not addressed the areas of concern found during our inspection visit and this placed people at risk of harm. We discussed this with the nominated individual who told us that they were planning an independent full quality audit at Sternhill Paddock. However, this had not yet taken place.

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

In other areas , there were in systems and processes to monitor and improve the quality of the service. The management team conducted a range of audits and checks across the service such as the environment and infection control. Records showed that these systems were, on the whole, effective in identify areas for improvement and bringing about change. Where issues had been identified, actions were recorded as having been taken. For example, a recent health and safety audit had identified that a member of staff required training. Action was recorded as having been taken and training records confirmed this to be the case.

There were clear policies in place which indicated physical intervention should be used as a last resort and emphasised the need for least restrictive practice. The quality and compliance manager told us that they had signed up to a local initiative to eventually phase out the use of restrictive physical interventions. However, there were no clear plans in place about how the provider was working towards achieving this goal and further work was required to implement an effective strategy.

During this inspection we found that the registered manager had not always notified CQC of events that they are required to by law. There had been a failure to notify us of a significant number of serious injuries which had been sustained by people who used the service. A failure to notify CQC of incidents has an impact on our ability to monitor the safety and quality of the service. We discussed this with the registered manager during inspection visit, they informed us that they had misunderstood their duties to notify CQC and advised that action would be taken to address this. Following our inspection we received notifications as required.

People who used the service were supported to have a say in how the service was run. Regular one to one meetings were held for people who used the service. We saw records of these meetings which showed that they were used to discuss topic such as their wellbeing, activities and food. The provider was also in the process of undertaking a customer satisfaction survey, the results had not yet been collated at the time of our inspection. The relatives of people who used the service told us that they felt comfortable approaching the registered manager or staff team should they need to. One person's relative told us, "They (staff and managers) take on suggestions and try and implement it and then feedback."

Staff were given an opportunity to have a say about the service in regular staff meetings. Records of these meetings showed that they were used to provide feedback to the team, share information and discuss the care and support of people living at the home. For example, a recent meeting focused on discussing learning and exploring alternative strategies for supporting one person who used the service. Staff told us they felt able to make suggestions about the service and said the registered manager acted upon their suggestions. One member of staff told us, "We can throw in ideas and (registered manager) listens." Another member of staff said, "(registered manager) listens to ideas and supports us saying, "Run with it." Staff also told us they felt supported and said they would feel comfortable raising any concerns with the registered manager or provider.

Staff were positive about the approach of the registered manager, using words such as "approachable",

"hands on" and "committed" to describe him. The registered manager was passionate about his role and had a clear vision for continually improving and developing the service. The registered manager explained that they kept up to date with best practice in a number of ways, including; linking with other local registered managers employed by the provider and working with external specialists. Throughout our inspection both the registered manager and provider were receptive to feedback and worked swiftly to address any areas of concern. Following our visit the registered manager took action to develop an action plan based upon the feedback we shared. The nominated individual also informed us that improvements were planned to the governance of the organisation, which they hoped would have a positive impact on the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with their care and incidents were not analysed to reduce risk of recurrence. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate action was not taken to ensure that people were protected from abuse and improper treatment. Regulation 13 (1) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality and safety of the service were not effective. Appropriate action was not taken to investigate incidents which posed a risk to the health and wellbeing of people who used the service. 17 (1)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Recruitment procedures were not effective in ensuring that persons employed are appropriately checked to ensure their suitability to work with vulnerable people.

Regulation 19 (1) (2) (3)