Community Places Limited

Community Places

Inspection report

43 Johns Street
Great Houghton
Barnsley
South Yorkshire
S72 0EA

Tel: 01226755070
Website: www.communityplaces.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This inspection took place on 3 and 10 May 2017 and was unannounced on the first day and announced on the second day. The service was last inspected on 22 September 2015. At that time the service was meeting the regulations.

Community Places is a 16-bed service for people with a learning disability or mental health needs. The home is in a residential area in the village of Great Houghton. The home comprises of 13 bedrooms with en suite facilities. Some of the bedrooms have been converted to provide people with their own private living area and one person had a self-contained apartment. At the time of our inspection eight people were living at the service and eight people were using the service occasionally for respite care. One person lived in a bungalow nearby. The service has a purpose built resource centre with an IT suite and an independent kitchen facility which has been specially designed for teaching.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe. Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Effective recruitment and selection processes were in place and medicines were managed in a safe way for people.

There were enough staff to provide a good level of interaction. Staff had received an induction, occasional supervision, appraisal and role specific training. This ensured staff had the knowledge and skills to support people who used the service.

People's mental capacity was not always considered when decisions needed to be made and evidence of best interest processes was not always available. This meant people's rights were not always protected in line with legislation and guidance. This was a breach of Regulation11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were met and they had access to a range of health professionals to maintain their health and well-being.

Staff were caring and supported people in a way that maintained their dignity and privacy. People were supported to be as independent as possible throughout their daily lives.

Individual needs were assessed and met through the development of detailed personalised care plans and risk assessments. Some people's annual person centred reviews were being planned to set more long term goals.

People and their representatives were involved in care planning and reviews. People's needs were reviewed as soon as their situation changed.

People engaged in social activities which were person centred. Care plans illustrated consideration of people's social life which included measures to protect them from social isolation.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

People told us the management of the service had been inconsistent in recent times; however, this had now been addressed. The company directors and management team were visible in the service and knew the needs of people who used the service. The culture of the organisation was open and transparent.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on.

The registered provider had an overview of the service. They audited and monitored the service to ensure the needs of the people were met but this system had not identified and addressed some of the concerns we found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had a good understanding of how to safeguard people from abuse. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Staffing levels had been assessed to ensure a good level of interaction. Recruitment procedures were robust.

Medicines were managed in a safe way for people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity was not always considered when decisions needed to be made.

Staff had received specialist training to enable them to provide support to people who lived at Community Places.

People were supported to eat a balanced diet and had access to external health professionals.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

People's care plans contained sufficient and relevant

information to provide consistent, person centred care and support. Some respite care records were in the process of being updated.

People were supported to participate in activities both inside and outside of the service.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The culture was positive, person centred, open and inclusive.

The management team and directors were visible within the service.

The registered provider had not identified and addressed some of the concerns we found.

Community Places

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 3 and 10 May 2017 and was unannounced on the first day and announced on the second day. The inspection was conducted by two adult social care inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One adult social care inspector conducted the second day of the inspection.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan the inspection.

Some people who used the service communicated non-verbally and as we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time with them observing the support people received. We spoke with four people who used the service and four relatives. We spoke with three support workers, two senior support workers, one deputy manager, three directors of the service and the cook. We looked in the bedrooms of five people who used the service with permission and also visited the bungalow. We received feedback from three community professionals.

During our inspection we spent time looking at four people's care and support records. We also looked at four records relating to staff recruitment, training records, incident records, maintenance records, feedback from people and a selection of the service's audits.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Community Places. One person told us, "I feel safe with the staff here."

We saw safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and CQC had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One staff member said, "If I was concerned about a manager I would report to [name of director] and CQC straight away. Things are dealt with straight away."

We saw information around the building about reporting abuse and whistleblowing. One staff member told us they had reported concerns about a previous registered provider and they would not hesitate to do so again if the need arose.

Systems were in place to manage and reduce risks to people. In people's care records we saw comprehensive risk assessments to mitigate risk in areas including accessing the kitchen, behaviour that may challenge, choking, physical health, hygiene, falls, finances, medication and using transport. We saw these assessments were reviewed regularly, signed and up to date. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence. This showed the service had a risk management system in place which ensured risks were managed without impacting on people's rights and freedoms.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded in detail and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they were keeping an overview of the safety of the service.

A call system was in place around the building which staff or people could use to summon staff assistance if needed.

Relatives told us there were enough staff on duty, however, agency staff were often used, which could affect consistent care for their relative. One relative said, "Yes, [name of person] is happy in the home. My only concern is the turnover of staff and at times they are short staffed and using agency staff." A further relative said the staffing levels had always been okay and their relative got to do the activities they enjoyed with staff support.

Staff told us there were enough staff on duty and staff picked up extra shifts to cover for sickness if required. One staff member said recently they had been short of staff due to sickness and occasionally this could impact on people's activities, but agency staff could be used. Another staff member said there were, "Appropriate levels of staff. When agency is needed we use staff that know the service."

The manager told us each person who used the service was allocated staff according to their assessed needs and we saw this was reflected in their care records and tallied with the number of staff on duty. We looked at historic rotas and saw 11 staff were on duty during the day, including one floating senior and one floating staff member, as nine staff were required to meet people's assessed needs plus extra staff when people used the respite service. We saw appropriate staffing levels on the days of our inspection which meant people's needs were met promptly and people received sufficient support. Managers and directors were on call out of office hours to support and advise senior support staff if required.

The provider had recently recruited new staff to the service and were awaiting pre-employment checks. The provider had their own bank of staff to cover for absence and asked permanent staff to do extra shifts in the event of sickness. Regular agency staff were also used. This meant people were normally supported and cared for by staff who knew them well.

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people. For example, the provider ensured references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed staff had been properly checked to make sure they were suitable and safe to work with people.

We found appropriate arrangements were in place for the management of medicines. The manager told us all staff at the home completed training in safe administration of medicines and we saw certificates to confirm this. Staff told us they completed training in medicines administration and then completed 10 medicines rounds with support before being signed off as competent. We saw staff competence in giving medicines had been assessed and plans were in place to continue to assess this annually. This meant people received their medicines from people who had the appropriate knowledge and skills.

Staff we spoke with had a good understanding of the medicines they were administering and we saw medicines being administered as prescribed. People's medicines were stored safely in secure medicines cupboards.

We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. Staff maintained records for medicines which were not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. We saw a stock check was completed daily and administration of medicines was checked and signed by two members of staff. This demonstrated the home had good medicines governance.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. No controlled medicines were being administered at the time of this inspection; however, suitable secure storage was available should these be required.

Medicines care plans contained detailed information about medicines and how the person liked to take them, including an individual 'as required' (PRN) medication protocol for the person. Having a PRN protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. This meant people were protected against the risks associated with medicines because the

provider had appropriate arrangements in place to manage medicines.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing. Checks had been completed on fire safety equipment and fire safety checks were completed in line with the provider's policy. A series of risk assessments were in place relating to health and safety.

People had a detailed personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. A fire training sheet was signed by staff and fire drills occurred regularly. The staff we spoke with knew what to do in the event of a fire or if the building needed to be evacuated. This showed us the home had plans in place in the event of an emergency situation.

The service was very clean and odour free, despite the very significant hygiene challenges created by the behavioural support needs of some people who used the service.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they were confident the staff team at Community Places could meet their relation's needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

Staff at the service had recently completed training and had a good understanding of the MCA 2005. One staff member said, "Have they got the mental capacity to make a decision? If it's a big decision there would be a meeting." We asked the operations director about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. We saw three people were subject to DoLS authorisations with no conditions attached and three people were awaiting authorisation. Three further people had been assessed as having mental capacity to decide to live at the home.

We saw in the care records we sampled mental capacity assessments had been completed where necessary in relation to each section of the care plan, however where people were assessed as lacking capacity to make the decision no best interest records were completed. No mental capacity assessments and best interest decisions had been recorded in relation to restrictions in place such as door sensors or night time monitoring devices. This meant the rights of people who used the service were not protected in line with the requirements of the Mental Capacity Act 2005. This was breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the operations directors told us they had spoken to the relevant people when making decisions in the best interests of people who used the service and they would ensure these best interest discussions were recorded.

Care plans and incident records showed physical intervention was only used as a last resort where harm may come to the person concerned or to those close by and methods of restraint were the least intrusive possible. Staff we spoke with were able to describe de-escalation techniques and how they minimised the use of restraint. This meant the human rights of people who used the service were protected and they were not unlawfully restrained.

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. We asked three staff what support new employees received. They told us they completed induction training and then shadowed a more experienced staff member for around ten shifts before they were counted in the staffing numbers. The shadowing focused on getting to know people's individual needs and preferences. One staff member said, "My induction was absolutely fantastic. I had plenty of support and lots of shadowing." This demonstrated new employees were supported in their role.

We looked at the training records for three staff and saw training included infection prevention and control, emergency aid, food hygiene, moving and handling, The Mental Capacity Act and DoLS, autism awareness, and safeguarding adults. Staff told us and we saw from records they also completed specialist training in management of actual and potential aggression (MAPA). We saw from the training matrix almost all training was up to date and further training was planned onto the rota. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff we spoke with told us they felt appropriately supported by managers and they said they had supervision every few months, an annual appraisal and regular staff meetings. One staff member said, "I feel fully supported. There are plenty of people I can ask for help."

We sampled four supervision records and found three staff member had received regular supervision and further appraisal was planned. One bank (casual) member of staff had not yet received supervision in 2017 and had received minimal supervision in 2016. One of the directors told us this was because bank staff had not been allocated to a senior support worker for supervision and they rectified this by the second day of our inspection.

Staff supervisions covered areas of performance and also included the opportunity for staff to raise any concerns or ideas. This showed most staff were receiving regular management supervision to monitor their performance and development needs.

Staff told us communication was good. Three handovers a day were held between shifts and a daily handover sheet for each person was used, as well as a communication book to share information such as health issues, activities and incidents or concerns.

One relative said, "The food looks absolutely gorgeous. The cooks are really good."

People told us they enjoyed their meals and could choose what they wanted. Meals were planned around the tastes and preferences of people who used the service. Pictorial menus were on display. We heard staff offering a person who used the service a choice of meal and we saw they received the meal and drink of their choosing. Each person had a list of food likes and dislikes in their care records, which was used to inform meal planning and some people had individual space in their kitchen for personal food items.

The cook had a file in the kitchen with any special dietary requirements and tastes. We saw some people helped themselves to a drink and food and drink was offered to people throughout the day. Some people shopped for and cooked their own meals with staff support.

One relative said, "When [name of person] lost weight they were referred to the dietician. They then phoned me saying [name of person] had gained two pounds. They are on the ball."

We saw the individual dietary requirements of people were catered for, for example; one person who used

the service was supported to follow a vegetarian diet and some people had meals of specific consistency following advice form the speech and language therapy team. Meals were recorded in people's daily records. This included a record of food consumed, including where food intake was declined and details of the food eaten. People were weighed weekly to keep an overview of any changes in their weight. This showed the service ensured people's nutritional needs were monitored and action taken if required.

People had access to external health professionals as the need arose. During our inspection three community health professionals visited different people at the service. Staff told us systems were in place to make sure people's healthcare needs were met. Staff said people attended healthcare appointments and we saw from people's care records a range of health professionals were involved. This had included GP's, psychiatrists, community nurses, chiropodists and dentists, speech and language therapy and psychologists. This showed people who used the service received additional support when required for meeting their care and treatment needs.

People's individual needs were met by the adaptation, design and decoration of the service. We saw the house was homely and spacious and comfortably furnished. There were pictures, art and craft work completed by people who used the service and photographs and wall stencils in the communal areas and bedrooms. All rooms were en-suite and a special shower room was also available where people could select the music and lights they wanted. Textures were also embedded in the walls to promote a sensory experience. Specially weighted furniture was used to prevent it being deployed as a missile. This meant the design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring. One relative said, "Staff are great, [name of person] loves them." Another relative said, "[Name of person] is really happy there. The staff bend over backwards to provide [name of person] with care and support."

People who used the service told us they liked the staff and we saw there were warm and positive relationships between people. Staff we spoke with enjoyed working at Community Places and supporting people who used the service. One staff member said, "Staff genuinely care."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities. They used this knowledge to engage people in meaningful ways, for example, by engaging them in conversations about activities or playing music they knew the person liked.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We saw one person was reassured in a kind and supportive way when they were feeling low and experiencing a period of poor mental health.

People were supported to make choices and decisions about their daily lives. Staff used speech, gestures, photographs and facial expressions to support people to make choices according to their communication needs. We saw staff used Makaton with one person and staff told us some people had their own individual signs which staff had learned to use in order to aid communication. Makaton is a communication technique that uses speech, facial expression, gestures, signs and symbols to convey information

Some people living at the home had autistic spectrum disorders (ASD). We saw staff interacted with people with ASD with a structured and therapeutic approach. Staff helped people to develop social skills and manage stress. We saw the service used schedules and timetables to give the necessary structure and visual cues to people.

People appeared well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style.

We observed three people who used the service had their own bedroom door key in order to lock their bedroom door if they wished to do so. Staff knocked and asked permission before entering bedrooms. Staff told us they kept people covered during personal care and ensured doors were closed. People's private information was respected and records were kept securely in the office.

People's individual rooms were personalised to their taste. One person had a wallpaper motif that reflected their interests and people had chosen their furnishings and décor where possible. One person's flat contained all their CD's and DVD. Personalising bedrooms helped staff to get to know a person and helped to create a sense of familiarity and make a person feel more comfortable.

One person told us, "I do my own washing, shopping and cooking. I'm growing some beans."

People were encouraged to do things for themselves in their daily life, such as cooking, washing, cleaning and shopping. People were supported to maintain and develop their independence skills. Care plans detailed what people could do for themselves and areas where they might need support, for example; "[Name of person] should be given a choice of suitable clothing each morning, [name of person] will show some interest in what they would like to wear." This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

Staff were aware of how to access advocacy services for people if the need arose and two people who used the service had independent mental capacity advocates. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

No people who used the service were currently in need of end of life care, however, as some people were living with life limiting conditions the directors told us they were currently planning their approach to ensure people and their representatives were consulted regarding end of life plans and wishes.

Good

Is the service responsive?

Our findings

Through speaking with people who used the service and relatives we felt confident people's views were taken into account in planning their care. One person told us, "We have meetings. I help to set up my care plan."

One relative said, "The care is brilliant. [Name of person] is pain free and comfy. [Name of person] is really happy, really relaxed."

The relatives we spoke with told us the service met their family member's individual needs and involved them in planning their care. They also said staff knew their relatives well and were able to understand and anticipate their needs.

People were involved in planning their care and where this was not possible or not desired by the person their family, advocate and other relevant health and social care professionals had been involved. One person's care plan explained how to communicate with the person when verbal communication was limited due to fluctuations in mental well-being, for example, using pictures and cards to choose whether to have a bath or a shower. Another person's care plan said, "Speak slowly and softly. Give short direct instructions." One person had a packet of visual symbols in their daily records file for daily use with planning their schedule of activities. This showed the service responded to the needs and preferences of people who used the service.

We found care plans were person centred and explained how people liked to be supported. For example, entries in the care plans we looked at included, "I liked to have structure to my day and a consistent approach." And I like, "Walking, listening to music on my tablet and day trips." This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

Care plans were detailed and covered areas such as domestic skills, accessing the community, medication, sleep, social skills, physical health, finances, education and recreation. The service was currently reviewing care plans to ensure each person's short term and long term goals were included and some of these reviews had been completed.

Care plans also contained detailed information about people's individual behaviour management plans, including details of how staff would care for people when they exhibited behaviours that challenged, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. Some people had a detailed script of how each aspect of their day should be organised in order to reduce the possibility of behaviour that may challenge others. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

People's needs were reviewed as soon as their situation changed. Reviews were held regularly and care

plans were evaluated and updated monthly or when needs changed. There were some recent gaps in monthly evaluations, however, where needs had changed these had been updated in the care plans we sampled. These reviews helped monitor whether care plans were up to date and reflected people's current needs so any necessary actions could be identified at an early stage. The service was also in the process of reviewing some respite care records to ensure they were all up to date.

Detailed daily records were kept recording peoples activities, mood, the care provided and a monthly evaluation was also completed.

People told us they were able to access activities in line with their tastes and interests. One person said, "I go to the gym. I go to Leeds now and again on the train or the bus." A second person told us, "They take me out to the football."

Staff spoke with good insight into people's personal interests and we saw from people's care plans they were given many opportunities to pursue hobbies and activities of their choice. An activity room was available for people and the theme of the week was British wildlife. People had made scrap books and bird boxes. A sensory room was being used by one person who wanted quiet time to themselves in a comfortable environment. One person returned from a trip to a local water park and was very happy about their experience bouncing on the bouncy castle there. Some people went out for a picnic as the weather was nice. On the second day of our inspection a new trampoline and safety surround was being installed in the garden for people to enjoy.

We saw from records people had taken part in activities both inside and outside the service. Some historic activity records were limited; however, improvements had recently been made in the recording of activities.

People told us they were enabled to see their families as often as desired and some relatives were visiting people on the days of our inspection. Staff accompanied people on family visits where required or supported relatives to take people out in the community. This meant staff supported people with their social and relationship needs.

People we spoke with told us staff were always approachable and they were able to raise any concerns. One person told us, "Staff used to wear a uniform. You get stigmatised. I complained. Staff now wear their own clothes." We saw there was an easy read complaints procedure on display. Staff we spoke with said if a person wished to make a complaint they would facilitate this. A complaints box was also available for people to use. We saw the complaints record showed where people had raised concerns these were documented and responded to appropriately. Minor verbal concerns had also been documented and addressed. Compliments were also recorded and available for staff to read.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us the service was well-led but there had been a number of management changes over the last year. One person said, "This has been a good place for me. It's a nice place to live. If I have a problem I report it to [name of deputy] or [name of director]. The managers keep chopping and changing."

A relative said, "At first it took a while for the concerns I raised to be addressed. The seniors are very good, they ring up. The management listen to what you say."

One community professional said, "My findings in general have been the staff, management and directors care about the service and the individuals they provide support for, however, a lack of consistent leadership has affected moral."

A further community professional told us numerous changes in management had been problematic for consistency, however, "We have had many meetings with [names of directors] and these have proven to be most valuable and productive and we are made welcome at any time without prior notice of us attending. Staff are receptive to our interventions and welcome our expertise. I would have no qualms in saying the service provided is of a good quality."

At the time of this inspection the service did not have a registered manager in post. A manager commenced employment at the service in January 2016 and their registration as manager was confirmed by CQC in September 2016. They left the service in December 2016 and a new manager commenced employment. This manager left the service in April 2017. A manager had been appointed and was due to commence employment on 15 May 2017. The registered provider consisted of three company directors, all of whom had based themselves at the service in the absence of a registered manager to provide management support to staff.

The management structure had recently been improved to include two senior support workers on each shift. This allowed one senior support worker to work on the floor with staff providing support and direction.

A separate manager was responsible for the bungalow, although they were absent from work at the time of this inspection. A deputy manager was in post there, and they were completing some management responsibilities at Community Places, such as reviewing incident reports.

Most staff we spoke with were positive about the registered provider and told us the home was well led. Staff said, "I think this is a really fantastic care home." "Management are approachable. [Name of director] phones on weekends," and "The staff atmosphere is not great. The care is top but there is a lack of activities."

The management team were visible in the service and senior support workers regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and

preferences of the people they supported.

The registered provider said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this. The senior staff told us they felt supported by the registered provider, and were able to contact a senior manager at any time for support. One staff member said, "I can go to the seniors or if I had any major concerns I could go to [name of director]." Another staff member said the directors were, "All approachable and lovely. It is homely because [name of director] is here and she cares."

The operations director told us their vision for the service was to meet people's aspirations and enable people to move forward, for example, by moving into more independent accommodation if they wished to do so.

Most incident reports had been reviewed by the deputy manager of another service and consideration given to ways to reduce future incidents. Three of the nine incident reports we sampled had not been reviewed, however, a multi-disciplinary meeting had been arranged in response to one of the incidents to discuss ways to reduce the re-occurrence. The registered provider told us they would ensure all incidents were reviewed by a manager and an immediate debrief provided to support staff following incidents of behaviour that may challenge.

An analysis of incidents had been completed by the registered provider to look for trends and patterns in behaviour with a view to preventing future incidents. The operations director told us they were planning to add these to their audit to ensure they were completed for each person every month. This demonstrated they were keeping an overview of the safety of the service.

We spoke with the new manager of the service following our inspection and they added they aimed to further improve behavioural analysis systems at the service and promote more structured activities with people so they were as fulfilled and engaged as possible.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on. We saw the home had sent out a satisfaction surveys to people who used the service, family members and healthcare professionals in November 2016. Any issues raised had been analysed and addressed by managers. This meant people's views were taken into account and they were encouraged to provide feedback on the service provided.

One relative we spoke with suggested a relatives meeting would be helpful for relatives and could improve the service. The director we spoke with said they were already considering starting relatives meetings.

Staff meetings were held every few months. Where staff meetings were held to impart information to teams, praise was given and recorded as well as areas to improve. Topics discussed included staff training, individual resident's needs, record keeping, management changes and health and safety. Actions from the last meeting were discussed and goals were set from the meeting. Meetings had also been held with senior staff and housekeeping staff. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

Staff suggestions were recorded in the complaints and feedback file and we saw some of these had been acted on, such as garden water play items and a DVD player for the lounge. A staff survey had been completed and the results of this had not yet been fully analysed, however, most responses were positive.

The service held a series of events for families and members of the community, such as a spring, summer and autumn fair.

The directors told us they attended training and good practice events, as well as working closely with local clinical commissioning groups and community teams to drive up quality in the service. This meant they were open to new ideas and keen to learn from others to ensure the best possible outcomes for people who used the service.

There were quality assurance systems in place designed to both monitor the quality of care provided and drive improvements within the service.

We saw audits were completed in relation to premises and equipment. Audits of medicines were completed monthly as well as regular infection control and recruitment file audits. Care plans and documents were also reviewed and audited regularly. A care plan audit in January 2017 had identified the need to complete a best interest process around food restrictions for one person and this action had been completed and for another person their goals were to be discussed with them and recorded. An audit of daily food and fluid records had identified some gaps in recording which were addressed with staff and improvements made. A supervision and appraisal audit had identified three people requiring annual appraisals and we saw dates had been set for these. This showed staff compliance with the service's procedures was monitored.

Information was normally passed to the registered provider by the manager every month regarding incidents, complaints, supervision, health and safety and other issues. The operations director was currently based at the service in the absence of a registered manager and had completed a monthly audit report to ensure compliance with the registered provider's' policies and procedures. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation; however, this system had not identified and addressed some of the concerns we found.

The previous inspection ratings were displayed. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about 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 11 HSCA RA Regulations 2014 Need for consent People's mental capacity was not always considered when decisions needed to be made and best interest processes were not evidenced.