Newlife Care Services Limited

Stocksfield Square

Inspection report

1-2 Stocksfield Square
Mount View Terrace
Stocksfield
Northumberland
NE43 7HL
Tel: 01661 844134
Website: N/A

Date of inspection visit: 10 and 11 August 2015
Date of publication: 14/10/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

Stocksfield Square provides accommodation and personal care and support for up to 10 people with learning disabilities. At the time of our inspection there were nine people living at the service.

This inspection took place on 10 and 11 August 2015 and was unannounced.

The last full inspection of this service was in July 2013. We found two breaches in relation to supporting workers and the safety and suitability of premises. In January 2014 we visited the service again to make sure the provider had met the requirements of the two regulations that had previously been breached, and we found that they had.

A registered manager is required under this service's registration with the Care Quality Commission (CQC). At the time of our inspection the name of a registered manager appeared on our register and website, who had not been in post since May 2015. Their name appears because they had not formally cancelled their registration

Summary of findings

with the CQC after leaving the organisation. We are pursuing this matter separately with the provider. The deputy manager of this home was covering the registered manager's post, whilst it remained vacant and recruitment was undertaken. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Most people were unable to tell us what they thought about living at the home as they could not communicate verbally due to the nature of their condition. Those who could, told us they felt safe living at the home. There were systems in place to protect people from abuse and channels through which staff could raise concerns. Staff were aware of their responsibilities to protect people from abuse.

People's needs and the risks they were exposed to when going about their daily lives had been appropriately assessed. Regular health and safety checks were carried out on the premises and on equipment used during care delivery. However, the provider had failed to identify concerns related to the premises and they had not ensured the premises were safe and secure. Not all environmental risks within the home had been assessed and not all areas of the home and equipment that people came into contact with were clean. This exposed people to the risk of catching an infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which is entitled 'Safe care and treatment'. You can see the action we told the provider to take at the back of the full version of this report.

Medicines were managed and administered safely. Recruitment processes were thorough and included checks to ensure that staff employed were of good character, appropriately skilled and physically and mentally fit. Staffing levels were determined by people's needs. Staff records showed they received regular training and that training was up to date. Supervisions for staff were conducted regularly and staff confirmed they could feedback their views during these meetings with the deputy manager.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. We found that applications had been made for DoLS for all of the people living at the home. In addition, people's ability to make informed decisions had been assessed and the 'best interest' decision process had been followed and details of individual decisions documented within people's care records.

Staff received appropriate training and supervision which was up to date. An appraisal system was in place and following the change in management, the deputy manager told us that appraisals were due to be carried out in the very near future.

Records confirmed that people's general healthcare needs were met and care plans and risk assessments related to people's care were regularly reviewed. People's general practitioners were contacted where there were concerns about their welfare and other healthcare professionals were also involved in their care, such as occupational therapists. People's nutritional needs were met and where necessary, their weight and food and fluid consumption was monitored to ensure that they remained healthy. Specialist nutritional advice and input to people's care was sought and implemented where necessary.

Our observations confirmed people experienced care and treatment that protected and promoted their privacy and dignity. Staff displayed caring and compassionate attitudes towards people and people's relatives spoke highly of the staff team. People had individualised care plans and risk assessments and staff were very aware of people's individual needs. People enjoyed trips out into the community with the support of staff and several people attended day care centres on a weekly basis and participated in a range of activities.

We received positive feedback about the leadership and current management arrangements in the home, from people, their relatives and staff. A complaints policy and

Summary of findings

procedure was in place but there had not been any complaints made about the service in the last 12 months for us to review. The deputy manager told us that complaints about the service were rare.

Systems were in place to monitor the service provided and care delivered. However, not all issues were identified and addressed by the provider. For example, we identified risks associated with the premises and infection control which had not been identified and addressed by management via the audits and checks that were in place.

We recommend the provider revisits their quality assurance systems and processes to ensure that all issues are appropriately identified and addressed in a timely manner.

Summary of findings

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

Not all elements of the service were safe.

Window restrictors had not been fitted to the premises to ensure people remained safe and the premises were secure. Environmental risks had not always been appropriately assessed.

Cleanliness levels in the home were not of an acceptable standard. There was a risk that people may be exposed to the risks of catching an infection.

Safeguarding procedures were in place and staff had been appropriately trained. Medicines were managed safely and staffing levels were maintained at a level that met people's needs.

Is the service effective?

Good

The service was effective.

People experienced care that was individualised and effective in meeting their needs. Staff were skilled, experienced and supported to maintain their skill sets and they told us they received regular supervisions. An appraisal system was in place and plans were in place to undertaken these in the near future.

People's nutritional needs had been assessed and where appropriate people received the support they needed to eat and drink sufficient amounts. People had input into their care from external healthcare professionals, as and when necessary.

The provider acted in line with their responsibilities under the Mental Capacity Act (2005) and 'best interest' decisions were made appropriately on people's behalf where they did not have the capacity to make decisions for themselves. Applications had been made to the local safeguarding team to ensure that no person had their freedom inappropriately restricted.

Is the service caring?

Good

The service was caring.

Staff displayed caring and compassionate attitudes when delivering care. People's relatives spoke highly of the staff team.

People were treated with dignity and respect and their privacy was promoted. They were encouraged to be as independent as possible.

No person living at the home accessed advocacy services but this could be arranged if needed in the future.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People experienced care that was individualised and staff responded to their needs. Where necessary management requested support from external healthcare professionals to address concerns.

People's care records were individualised and person-centred. They were reviewed regularly and where necessary, updated in light of changes in people's care needs.

Complaints about the service were rare but a complaints policy and procedure was in place. People, their relatives and staff were given the opportunity to feedback their views about the service directly to the deputy manager, in meetings or via the completion of surveys.

Is the service well-led?

Requires improvement

Not all elements of the service were well-led.

A registered manager was not in post or managing the service at the time of our inspection. Temporary management arrangements were in place.

Meetings were held in the home for staff and people who used the service to discuss any concerns and issues related to meeting people's needs.

Quality assurance systems were in place, but some issues had not been identified and acted upon.

Stocksfield Square

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 10 and 11 August 2015 and was unannounced.

The inspection team consisted of one inspector.

Prior to our inspection we reviewed the provider information return (PIR) that the provider sent us in advance. This is a form which asks the provider to give some key information about the service, highlighting what the service does well and identifying where and how improvements are to be made. In addition, we gathered and reviewed information that we held about the service. This included reviewing statutory notifications and any other information that the provider had sent us over the last 12 months. We contacted the commissioners of the service, the local authority safeguarding team and Healthwatch (Northumberland) in order to obtain their views about the service. We used the information that they provided us with to inform the planning of our inspection.

During the visit we spoke with three people who lived at Stocksfield Square, four members of the care staff team and the deputy manager. We walked around each floor of the home, all communal areas such as lounges and dining rooms, the kitchen, and with permission we viewed people's bedrooms. We observed the care and support people received within the communal areas. We analysed a range of records related to people's individual care and also records related to the management of the service. We viewed four people's care records, seven staff recruitment records, eight training and induction records, all nine people's medicines administration records and records related to quality assurance, health and safety matters and the servicing of equipment.

Where people could not engage with us verbally, we observed the care they received to help us understand their experiences. Following the inspection we spoke with two people's relatives to gather their views about the service. In addition, we attempted to contact five healthcare professionals linked with the home and obtain their feedback about the care delivered and the leadership of the service. We received feedback from three healthcare professionals and we have considered their views about the service when making our judgements. The views of people's relatives and healthcare professionals are reflected in this report.

Requires improvement

Is the service safe?

Our findings

We identified concerns with the premises, equipment and cleanliness during our inspection.

There were no window restrictors on any of the windows in the building. This meant that there was not only the potential for people to injure themselves, but this also posed a security risk. Staff told us they felt vulnerable at times, particularly in the evenings, as windows were opened to allow air to circulate around the building. We discussed this with the deputy manager. She told us that at one stage there may have been window restrictors on some of the windows within the home, but these had been removed, although she did not know why.

Externally the building was not well maintained. The window and door frames were degrading in places and paintwork had either come off altogether, or was flaking off on the majority of windows and doors. The deputy manager told us that to her knowledge the window frames and doors had not been replaced or repainted for over 15 years. Internally, the home looked tired and in need of decoration in most communal areas, such as the dining room and kitchen. Door frames and skirting boards were in need of repainting where equipment such as wheelchairs and chairs had come into contact with them and the paint had come off. In the downstairs shower room paint was coming off the ceiling and the windowsill and in the manager's office a leak from the laundry room upstairs had damaged the ceiling some time ago and this had not been repaired.

A radiator in the hallway was leaking and a glass bowl was in place to collect any water that escaped. Some toilet seats were broken, the plastic or enamel coating had come off in areas of others and one toilet upstairs had a sizeable hole half way up the basin. Some equipment in the bathrooms such as showering chairs was rusted in areas and one bath panel was worn with paint coming off. Equipment that people had contact with posed an infection control risk, as it was not appropriately cleaned. Such equipment included toilet seats, most of which were dirty on the underside. The carpets in the corridor areas and on both staircases within the home were in need of vacuuming and the flooring in the downstairs shower room was black in the corner areas where it was upturned and had not been appropriately cleaned to prevent the build-up of mildew and mould.

We looked at the management of risks within the building. Regular fire and health and safety checks were carried out and documented and equipment such as hoists and the lift were serviced. However, an electrical installation safety check had not been carried out in line with statutory obligations. In addition, a legionella risk assessment of the building had not been carried out in line with the requirements of the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and the Health and Safety at Work Act 1974. Paperwork issued to the service by a third party in August 2014 reminded them of their obligation and the requirement to carry out a legionella risk assessment on the building, however, this had not been addressed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled 'Safe care and treatment'.

Only a small number of people who lived at the home were able to converse with us verbally. One person told us, "I like it here." In answer to the question 'Are you happy living here?' each person we spoke with replied "Yes". Relatives confirmed that they had not witnessed anything when visiting the home that gave them cause for concern. One relative told us, "I have never seen anything that worries me when visiting the home."

We observed staff whilst they delivered care and supported people. They adopted moving and handling procedures that were both appropriate and safe and we had no concerns about people's safety or how they were treated by staff. We saw one person walking around the communal areas of the ground floor of the building in their socks and they were encouraged and supported to put their slippers on, to reduce the risk of falling or injury to their feet. Another person was advised to take their time when ascending the stairs so that they did not rush and potentially trip.

Risks that people were exposed to in their daily lives, which were linked to their needs and health conditions, had been assessed and documented. For example, risk assessments were in place for people whose behaviours that may be perceived as challenging and those who neglected their own personal care. There was evidence within individuals' care records that these risk assessments were reviewed regularly and staff told us that as people's needs changed, these assessments were updated. Positive risk-taking took place and was managed safely. For example, people were

Is the service safe?

supported to access the community and pursue activities that they enjoyed, despite any physical and learning disabilities they had. People's care records evidenced that care reviews took place involving outside professionals including GP's, local authority care managers and other health and social care professionals such as district nurses and psychiatrists. This meant that multidisciplinary teams looked at people's care, the risks associated with it and if care provision was safe.

Records were maintained of accidents and incidents that occurred so they could be monitored. These records showed that since January 2015, there had been six accidents or incidents involving people who lived at the home. None of these accidents or incidents were of a serious nature and none had resulted in people suffering a serious injury. The deputy manager analysed these accidents/incidents, looking at the time they occurred and the people involved, with a view to identifying any trends where remedial actions could be taken to prevent repeat events. The deputy manager told us, "We have very few accidents and incidents here that result in injury. It is just things like people accidentally sliding off their chair."

On the days of our visits there were enough staff readily available to assist people when they needed help and support. People had regular contact with staff and we saw that their needs were met in a timely manner. Most people were in the communal areas of the home throughout our visit. We had no concerns about care based staffing levels within the service. Night staffing levels consisted of one waking staff member and one member of staff who slept in the building and could be called upon if necessary. In addition, the deputy manager confirmed that they were on call at any time and if they could not be contacted, the regional manager would be available should night staff require assistance or advice.

We discussed the concept of safeguarding and whistleblowing with both the deputy manager and care support staff. They were knowledgeable about different types of abuse, recognised their own personal responsibility to report matters of a safeguarding nature and were aware of the processes they should follow to ensure that people are protected. The provider had robust systems in place for managing people's money and recording their financial transactions. When we carried out a sample check of two people's money, the amounts tallied with the running balances maintained by the deputy manager. Our records showed that two potential safeguarding incidents had been raised about the service within the last 12 months. In both cases the claims brought against the provider, were investigated but not substantiated. Historic safeguarding cases had been referred to the appropriate local authority for investigation, in line with protocols.

Staff files demonstrated that recruitment procedures were appropriate and protected the safety of people who lived at the home. Application forms were completed and included details about staff's previous employment history. Potential new staff were interviewed, their identification was checked, references were sought and Disclosure and Barring Service (DBS) checks were obtained before staff began work. They were also introduced to people who lived at the home during the recruitment process to see how they interacted with people and how people responded to them. This meant the registered provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were appropriately qualified and physically and mentally able to do their job.

We reviewed each person's medication administration records (MARs) and found that these were well maintained. A current photograph of each person was attached to the MAR to ensure there were no mistakes in identity when staff were administering medicines. Protocols were in place for the administration of 'as required' medicines, although these were standard documents and not person-centred to people's needs. The deputy manager told us that this would be addressed and she would amend these protocols to be relevant to each individual person. Medicines were stored appropriately and we saw systems were in place to account for and dispose safely of medicines that were no longer required.

A business continuity plan was in place which contained a list of emergency contact details for staff and guidance about what procedures they should follow if a range of different scenarios occurred, such as a fire or a loss of utilities. Personal Emergency Evacuation Plans (PEEPs) were held within people's care records, which gave staff instructions about how to support each individual to exit the building, should this be necessary. A specific night emergency plan was also in place which provided staff with a list of contact numbers for staff to use if necessary, such as those for the local hospital, pharmacist and NHS direct.

Good

Is the service effective?

Our findings

We asked people we could converse with, about the care they received. One person told us, "I like it here." Relatives told us they were happy with the care that their family member received and they had no concerns about the service and care delivered. One relative said, "We have been very pleased with the home and have had no cause for complaint. We think staff go out of their way to meet X's (person) needs." Another relative told us, "They (staff) seem to understand X's (person) personality and needs."

Three healthcare professionals linked with the home informed us of their views about the effectiveness of the service. They described good relationships between staff and people who lived at the home and they told us people received good care. One healthcare professional said, "Staff interact well with the residents and show a good understanding of the individual needs of each resident." Another healthcare professional told us, "I have not seen anything that concerns me. Staff have a good relationship with people who live there."

Staff displayed an in-depth knowledge of people and their needs. The information they gave us tallied with our own observations and information held within people's care records. One member of staff told us, "If people's needs change, it is put in their care plans, so that all staff are aware." Where people could not communicate verbally, staff explained how they established people's moods and whether or not they were happy with a particular action or personal care task. They told us how they had learned to read people's facial expressions, noises they made and identify changes in their behaviours, to ensure that they could meet their needs appropriately and effectively. Staff told us that some people were able to communicate their needs by pointing to what they wanted, or by taking staff to a specific area within the home, such as the toilet or their bedroom if they wanted to go bed.

Consideration had been given to people's levels of capacity and their ability to make their own choices and decisions in respect of the Mental Capacity Act 2005 (MCA). The deputy manager told us that Deprivation of Liberty Safeguards (DoLS) were in place for all nine people living at the home. DoLS are part of the Mental Capacity Act 2005. They are a legal process which is followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. For example, a DoLS application would be necessary where a person with limited or no capacity needs to remain under constant supervision to protect their safety and wellbeing. These applications and decisions are made in people's best interests, by the relevant local authority supervising body.

In line with the MCA, the provider followed the principals of 'best interest' decision-making in practice where people did not have the capacity to make their own decisions. Records of best interest decision-making were retained and these confirmed the parties involved in the process and the discussions that had taken place. We discussed the importance of maintaining such records with the deputy manager. In addition, we discussed the importance of establishing whether an attorney had been appointed to act on people's behalf in respect of any health and welfare based decisions that may need to be made and then retaining records about this.

Menus were in place which rotated on a three week basis. There was a variety of healthy foods available to people and staff told us that people could choose an alternative if they did not like the meal planned for any particular day. Where people had specialist dietary requirements or nutritional needs, we observed staff supported them appropriately. For example, people were weighed regularly to ensure they remained healthy and evidence showed that significant fluctuations in people's weight had been identified and referred to external healthcare professionals for additional input and advice. Food and fluid intake charts were maintained to monitor people's consumption of food and drink if there were concerns about their weight. Two people who lived at the home were on calorie controlled diets and one person enjoyed telling us about their weekly trips to their local slimming club and their progressive weight-loss!

People's general healthcare needs were met and there was evidence that people were supported to attend routine appointments, for example at the doctors or dentists. In addition, where necessary, people had input into their care from specialists including occupational therapists, speech and language therapists and psychiatrists.

Staff told us they felt equipped with the appropriate skills to fulfil their roles, they had completed an induction when they first started working at the home and that they felt supported by the deputy manager. One member of staff said, "Training is kept up to date. I have done my medication, infection control and moving and handling.

Good

Is the service effective?

Training is always on-going. We do some in booklets, some online and some face to face. I prefer face to face training personally." Records showed that staff had been trained in key areas such as safeguarding and first aid. A training matrix helped the deputy manager track when any training needed to be refreshed. Staff had also received training in areas relevant to the needs of the people they supported. For example, staff were trained in end of life care, challenging behaviour, epilepsy and dementia.

Staff told us, and records confirmed that they received regular supervisions from the deputy manager. The deputy manager had also received supervisions from the area manager in the past nine months. Supervisions were used as a two-way feedback tool through which the supervisor and supervisee could discuss work related issues, training needs and personal matters. The deputy manager told us that over the last few years appraisals had fallen behind but this matter was in hand and an appraisal form was in place, and appraisal sessions to discuss staff performance in the previous year, would be arranged for all staff as soon as possible.

Staff reported that communication was good between themselves and the deputy manager. Messages were passed between the small staff team either verbally or via a communication book. A diary system was also maintained which contained information about up and coming events and any appointments for people who lived at the home. The area manager was kept abreast of any key issues at the service via a weekly report submitted to them by the deputy manager, unless the matter was more urgent and then they would be notified immediately. The deputy manager told us that communication between herself and the area manager was both regular and good.

Staff and the deputy manager told us that the home had been adapted in recent years to suit people's changing needs. For example, alterations had been made to the downstairs bathroom to create a walk-in wet room and a passenger lift had been installed in the home to enable people who were unable to use the stairs to move between the lower and upper floors. People's bedrooms were individually furnished and decorated and they contained people's personal items.

Good

Is the service caring?

Our findings

We asked one person if the staff were nice to them and they said "Yes". We asked them if staff were ever rude and they said "No". People's relatives told us they found the staff and service caring. They all spoke highly of both the staff team and the deputy manager who was covering the manager role. One relative said, "Staff are caring." Another relative told us, "Staff seem very proactive and they are sensitive to people's needs." One healthcare professional said, "The atmosphere at the home always presents as very relaxed and informal and individuals have plenty of living space to move around and take time out in their own space if required." Another healthcare professional commented, "One positive comment I would like to make is about the thoughtful and sensitive way in which staff cared for one of my clients whilst they were in the last stages of their life."

We reviewed some comments written in questionnaires sent out in May 2015 by the provider to gather the views of people's friends, relatives and healthcare professionals. Comments included; "I have always found the staff to be caring and helpful and can't thank them enough for their support for me when X (person) passed away"; "A staff team who genuinely care for the people they support"; and "This is a lovely caring home for the residents. Staff obviously have a lovely rapport with their patients. Their care and compassion is of a really high standard."

We observed care delivery and watched how staff interacted with people. There was a pleasant and calm atmosphere within the home. Staff spent time talking with people and reminiscing about recent events and activities that they had undertaken together. They displayed kind and caring natures and people responded positively to the interactions they experienced with staff. There was lots of excitement within the home about one person's up and coming birthday party, which was being held locally and was to be attended by people from this home, alongside friends from one of the provider's other services nearby.

Staff spoke with people who could not converse with them when delivering care, ensuring that they were kept informed at different stages. For example, one staff member asked a person, "X (person), can I just move you backwards (in their wheelchair) while I get past?" Staff discreetly observed people when they were eating their lunch and regularly asked them if they were alright, if they had consumed enough food and drink and if they had finished with their crockery, before clearing it away. People could not always answer, but staff were very familiar with their behaviours and could tell us when individuals were unsettled or upset. One person had intentionally broken their skin and staff told us they had behaved in this way because they were unsettled by our presence in the home, as we were strangers. The staff member was quick to assist the person by comforting them, dressing their wound and relocating them to a quieter area of the home.

Staff delivered care which promoted and protected people's diversity, dignity, privacy and

independence. For example, we observed staff closed toilet doors when delivering personal care and people had access to time and space on their own, if they wanted some privacy. People moved around the ground floor of the home independently, using mobility aids if necessary and staff encouraged them to do as much as possible for themselves. If needed, staff offered a gentle helping hand when people were walking. Specialised cups and crockery had been obtained for those people who required them, so that they could remain as independent as possible when eating and drinking. One person's care plan referenced that they liked to assist with household tasks such as washing the dishes. Staff told us that people contributed to cleaning their own bedrooms with their keyworker supporting them in this task, either fully or partially. This showed that people were supported to maintain their independent living skills as much as possible.

Staff we spoke with understood the importance of promoting people's privacy and dignity when supporting them with personal care. The layout of the home was such that private space was available for people to enjoy time with anyone who may visit them. Staff gave us examples of how they maintained people's dignity and respected their wishes. Training certificates showed that staff had undertaken training in equality, diversity and human rights and the provider had an 'Equality, diversity and inclusion' policy in place for staff to refer to.

Staff displayed caring and compassionate attitudes towards people resulting in them experiencing positive care delivery. People's relatives told us they were kept informed about changes with people's care and they felt fully informed. Care plans reflected people's life histories and staff were knowledgeable about people's likes, dislikes and the activities they liked to pursue.

Good

Is the service caring?

Pictorial signage was used around the home to inform people in a manner that was suitable and appropriate to their communication needs. For example, there was information about what people should do in the event of a fire and how to exit the building in an emergency. There was also a pictorial complaints guide on the noticeboard in the kitchen/dining area giving a step by step guide of how people could complain if they wanted to.

We asked the deputy manager if any person living at the home currently accessed advocacy services. She told us that no people living at the home had an independent advocate acting on their behalf, but that some people's families advocate for them. Advocates support people who may need encouragement to exercise their rights, to understand decisions they may need to make and to explore the choices and options available to them. The deputy manager told us she had good links with people's care managers and would contact them to arrange an advocate if this was necessary. In addition, she said that an advocacy service had recently visited the home and they were available to support people if necessary in the future.

Good

Is the service responsive?

Our findings

Relatives told us they felt involved in their family member's care and staff were aware of, and met people's needs. They said the service was responsive. One relative commented, "They have been responsive. They certainly let us know if there have been any concerns and they absolutely refer to doctors and dentists for example if needed." Another relative said, "They (staff) seem responsive to X's (person) needs."

The service operated a keyworker system where individual staff members were allocated to individual people living at the home. Keyworkers held responsibility for ensuring people's needs were met and that mechanisms were in place to enable them to achieve their goals and aspirations as much as possible. Care records were regularly reviewed and updated by people's keyworkers. Staff told us that all relevant parties were kept informed as and when needed, in respect of any changes in people's care needs. Care was very much person-centred. Staff told us they gave people who could not communicate verbally as much choice as possible in relation to day to day decisions and we witnessed this during our inspection. They told us they responded to people's needs by reading their emotions, expressions and behaviours they displayed.

People's care records contained a summary of their life history, their background, skills, interests, likes and dislikes. A comprehensive set of care and support plans had been developed that reflected their needs, which had been previously assessed. For example, there were care plans related to supporting people with their physical health, finances, accessing recreational activities and independent living skills. There was evidence of pre-admission assessments and of systematic reviews and evaluation to ensure that people's care remained appropriate, safe and up to date. Care monitoring tools such as personal hygiene charts and charts for monitoring people's behaviours were in place, where necessary. In addition, the service used daily evaluation records and had a diary system to pass information between the staff team and to respond to any issues that may have been identified.

External healthcare professionals told us staff were responsive to people's needs and they had involved general practitioners (GPs) and specialists in people's care when needed, to promote their health and wellbeing. Records we reviewed confirmed this. One member of staff told us, "We just get the GP out." One healthcare professional linked to the home said, "I feel that the home makes every effort to maintain excellent links with myself and is proactive in engaging with other services such as BAIT and psychology when needed or discussing this further with me. The staff are friendly and always happy to provide information when requested." A second healthcare professional told us, "Staff act upon the OT (Occupational Therapist) advice that is given."

Some people who lived at the home attended day centres weekly, where they were able to pursue a variety of different activities. The provider had access to a minibus that was shared between this home and a sister service. Staff told us they were able to take people out into the community regularly, to enjoy day trips to the coast for example, or visits to local shopping centres. We spoke with one person who told us they had enjoyed their day out in the community with staff and they had enjoyed a picnic in nice weather. People were supported to maintain close links with their families if applicable and relatives could visit the home at any time. This showed the provider promoted social inclusion and sought to maintain people's mental wellbeing.

A complaints policy and procedure was in place with details about how to complain and the timescales involved. There was also information about how to complain in a written and pictorial format displayed in communal areas and held in people's individual care records. This showed the service had responded to people's needs and presented them with information in an appropriate format. The deputy manager told us that there had been no complaints made about the service to her knowledge.

The provider had systems in place to gather the views about the service delivered. Surveys had recently been sent out to people's relatives, friends, external healthcare professionals and staff, in order to measure the standard of service delivered and to address any concerns raised. One healthcare professional had commented in a questionnaire in May 2015, "The care team always appeared eager to go the extra mile to ensure the clients are supported and had their individual needs met in a timely manner". Another comment made was, "An exceptional care home for people with learning disabilities. The staff are always really friendly and interact well with the client group."

Good

Is the service responsive?

The deputy manager and staff told us that staff and residents meetings took place bi-monthly. Staff told us they had the opportunity to feedback their views either during staff meetings, at one to one supervisions sessions or by approaching the deputy manager directly.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection the name of a registered manager appeared on our register and website, who was not in post and had not been managing the service since May 2015. Their name appears because they had not formally deregistered themselves with the CQC after leaving the organisation several months earlier. The deputy manager of this home was covering the registered manager's post whilst it remained vacant and recruitment was undertaken. We are pursuing this regulatory matter with the provider.

It was clear through our discussions with the deputy manager that she knew people well and sought to secure the best possible outcomes for them. She told us that she had worked at the home for many years and she assisted us on both of the days that we inspected.

We received positive feedback from people and their relatives about the deputy manager. One person said, "I like X (deputy manager)." The relatives we spoke with told us they enjoyed an open relationship with the deputy manager and said the home had a friendly atmosphere. One relative commented, "X (deputy manager) has always been open and honest with us. We feel that we can say what we want to and things get addressed. The home has been running smoothly." Staff also told us the deputy manager was extremely approachable and operated the service well. One member of staff said, "X (deputy manager) is very fair." Another member of staff told us, "X (deputy manager) is very approachable; you can go to her with any problems. If I had any issues I would say."

External healthcare professionals told us the deputy manager engaged with them regularly, respected their professional judgement and responded to any advice given. One healthcare professional commented, "Although there have been a few changes in the manager/deputy managers positions, I do not think that this has caused too much disruption to the ethos and running of the home." Another healthcare professional said, "The deputy manager has been providing management cover for some time and has known the individuals for many years and has a good rapport with them."

The deputy manager told us she worked in partnership with other agencies and enjoyed open working relationships with the healthcare professionals involved in individual's care. The atmosphere within the home was positive and the staff team told us morale had improved in recent months. The deputy manager told us she was open to staff approaching her at any time to raise concerns, issues, or to ask for assistance.

We found the provider had an overall assurance system in place to ensure that staff delivered care appropriately. Monitoring tools such as food and fluid intake charts were in place. Night staff completed checks on people regularly throughout the night and they were guided by people's overnight needs by a summary of information that was held communally. In addition, there were systems in place to monitor people's changing continence needs; their weight; any future health related appointments; a staff communication book for passing messages between staff; and a shift handover book where any issues that needed to be addressed or actioned were recorded. These tools enabled the deputy manager to monitor care delivery and then identify any concerns should they arise.

When asked, the deputy manager told us no management meetings took place but she felt fully supported by the area manager who she had regular contact with. Staff meetings and meetings for people took place on a bi-monthly basis where a variety of issues related to the operation of the service and people's individual needs were discussed.

The deputy manager told us, and records showed that a range of different audits and checks were carried out to monitor care delivery. These included medication audits, infection control audits and health and safety audits/ checks. The deputy manager told us that she completed a weekly report and submitted it each Friday to the area manager so that they were kept up to date with key issues related to the service that week and they could liaise with the provider if necessary. This report covered information about; staffing levels; training requirements; any accidents or incidents that may have occurred; safeguarding matters; complaints; visits from external professionals; audits completed; and any maintenance and repairs issues.

Although these audits and reports identified some matters that needed to be addressed, it was not always clear whether plans had been made to rectify these. Some audits and reports had action plans completed and attached to them and we could see that improvements had been made. For example, the hall carpet had been replaced where it was torn and was a health and safety risk. However, this was not consistent across the service.

Requires improvement

Is the service well-led?

Records showed that the deputy manager and previous registered manager had been highlighting the need for redecoration throughout the home for many months via auditing reports, but this had not always been addressed by the provider.

Records showed that the area manager had completed three 'Senior manager home visits' at regular intervals since January 2015. These visits essentially involved the area manager completing an overall audit of the service, including taking general observations, speaking with staff and residents, looking at care records, medicines management, complaints, accidents and incidents, safeguarding and whistleblowing issues (if any). The deputy manager told us the results of these senior management visits were shared with the provider by the area manager and they did not get any feedback about these visits, unless an issue was identified that the provider chose to address. There were no action plans linked to these 'Senior manager home visits' and some of the issues that we identified through observation at this inspection, such as cleanliness and premises issues, had not been recorded on these visit records and they had not been addressed.

We recommend the provider revisits their quality assurance systems and processes to ensure that all issues are appropriately identified and addressed in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and refurbishment. In addition, effective control measures were not in place to prevent the spread of infection, some equipment was not adequately maintained and environmental risks had not always been assessed. Regulation 12(1)(2)(b)(d)(e)(h).