Optalis Limited

5 Winston Court

Inspection report

5 Winston Court
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

5 Winston Court is a care home without nursing and provides accommodation and support to adults with learning disabilities or autism. The care home is located within a residential area of Maidenhead, Berkshire. There are two floors. On the ground floor are communal areas, the kitchen and laundry and some people's bedrooms. The first floor has more people's bedrooms, communal bathrooms and a staff office. In accordance with the current registration, the care home can accommodate up to eight adults. At the time of our inspection seven people lived at 5 Winston Court.

Our inspection took place on 22 September 2017 and was unannounced.

The service is required to have a registered manager. At the time of our inspection, a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected from abuse and neglect. Staff were trained in protecting adults at risk and told us they would report any instances to the management, local authority or other relevant agencies.

People's care risks were appropriately assessed by staff and recorded within their care files.

People were not always safe from premises risks. Although health and safety risks were assessed, the findings were not always promptly acted on by the provider. Remedial actions, such as repairs, were not communicated, planned or completed. The provider's health and safety coordinator was replacing prior systems of managing premises risks in order to ensure essential works were completed.

There were long-standing vacancies of permanent care workers. Staff routinely worked overtime, cancelled their annual leave or dedicated training and there was ongoing use of agency workers. Staff had accrued high volumes of annual leave because they sometimes did not have the ability to use it if they worked instead. A robust system of calculating the number of staff hours for each shift was not in place. We made a recommendation about staffing deployment.

People's medicines were satisfactorily managed.

Staff completed training, supervision and performance appraisals, but requirements were needed to ensure appropriate knowledge and experience was in place.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had adequate food and drinks. People's care was supported by healthcare professionals from the local area. The decisions of multidisciplinary healthcare teams were not always followed by staff when providing support to people.

Staff were friendly and enjoyed working with people who used the service. They knew people's likes, dislikes and preferences well. Staff respected people's privacy and dignity. We saw staff had a good understanding of people's needs.

Care plans were in place for people, and we found these were person-centred. We made a recommendation about the use of advocates. There was a complaints procedure in place, but this was not clearly displayed within the service. Easy-read versions were required for people who used the service. We made a recommendation about the complaints system at the service.

The provider's systems of measuring the safety and quality of care were not fit for purpose. Processes for the measurement of safe and quality care remained the same since a change in registration. Checks from the new provider were not in place. A service improvement plan was available but not updated with the latest information. Best practice in caring for people with learning disabilities or autism were not considered or put into place.

We noted there was a good workplace culture amongst the staff. They felt well supported by the registered manager and told us they could approach her about anything they wanted to raise or discuss.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were safely managed, but required minor improvements to ensure best practice.

A satisfactory system to determine safe staffing deployment was not in place.

Risks to people from the building and equipment were adequately assessed, but not always acted on.

People had risk assessments in place for their personal care, but these were sometimes inaccurate.

People were protected from abuse and neglect.

Is the service effective?

Requires Improvement

The service was not always effective.

People received support from skilled and experienced staff but training, supervision meetings and performance appraisals were inadequately recorded.

People had access to appropriate multidisciplinary care teams to support and promote their ongoing health. People's records for healthcare visits required improvement.

The service worked within the principles of the Mental Capacity Act 2005 and associated codes of practice.

People had appropriate access to food and drinks, but dietary advice was not always followed.

Is the service caring?

Good

The service was caring.

Staff were friendly and promoted people's independence.

People were supported by staff that knew them well and

understood their individual needs.

People's privacy and dignity was protected.

Is the service responsive?

Good

The service was responsive.

People's preferences for communication were recorded and staff used alternate methods of communicating with people.

People had an active social life within the community.

Care plans were personalised.

A complaints process was in place, but required some improvement.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The safety and quality of people's care was not consistently checked, recorded or acted upon.

Policies, procedures and operational processes from the current provider were not fully implemented in the service.

There was a positive workplace culture and staff worked well together to support people.

5 Winston Court

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.

Our inspection took place on 22 September 2017 and was unannounced.

Our inspection was completed by two adult social care inspectors.

This is our first inspection of the service since the change in provider.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public, local authorities, clinical commissioning groups (CCGs) and the fire inspectorate. We checked records held by Companies House, the Information Commissioner's Office (ICO) and the Food Standards Agency (FSA).

During our inspection we spoke with the provider's health and safety coordinator, the service's registered manager and four care workers.

We observed the care of five people. We looked at four medicines administration records and three sets of records related to people's individual care needs. This included care plans, risk assessments and daily monitoring notes. We also looked at three staff personnel file and records associated with the management of the service, including quality audits. We asked the registered manager to send further documents after the inspection and these were included as part of the evidence we used to compile our report.

We looked at the premises and observed care practices and people's interactions with staff during our inspection.

Requires Improvement

Is the service safe?

Our findings

We found each person had individual needs assessments in their support plan, which were in addition to the standard risk assessments staff completed for everyone. For example, where a person was known to be at risk in the community because of a lack of danger or hazard awareness, staff had prepared a needs assessment for when the person was accompanied on day visits to ensure they were protected from harm.

Staff completed a health needs assessment for each person and we saw this was reviewed monthly or when there was a change in condition. The health needs assessment included medical history, ongoing health conditions and risks and a list of current prescribed medicine. Staff also noted if the person was able to communicate if they had pain. Where an individual was not able to tell staff they were in pain, the care team had methods of identifying pain through facial expressions, a change in habits or body language. In addition to an individual needs assessment, care staff completed a skills assessment for each person. This was carried out when people first came to live at the service and staff documented updates on a six monthly basis. The skills assessment was to help identify if people could perform routine daily tasks for themselves such as brushing their teeth, bathing, using the toilet and sorting their own laundry.

Staff completed a series of risk assessments for each person, including for medicines, fire and evacuation and mobility. We found risk assessments were specific to each individual and included details of whether or not each person could self-administer their prescribed medicine or "as needed" medicines, such as painkillers. There was also evidence staff had explained fire procedures to people and had assessed other health and safety risks around the home, such as the use of kitchen equipment. This was balanced with a care focus of sustaining the person's independence. For example, one risk assessment identified the need to protect the person from scalds or burns in the kitchen but also identified that they enjoyed making their own drinks and food. This provided staff with an opportunity to promote a person's hygiene, such as the process for handwashing. Each risk assessment page included a photograph of the person it related to. This helped staff ensure they were always using the correct assessment.

However, we also found areas of inconsistency in the reviews and detail of risk assessments. For example, one person's risk assessments had not been updated in over nine months. In addition their fire and evacuation plan identified that they would be unable to hear a fire alarm due to hearing loss and identified risk mitigation as clear fire exit signs. This was insufficient because it did not identify how the person would know to follow fire exit signs if they could not hear an alarm if they were alone in their bedroom, such as during the night. We also found their bedroom had not been adapted with a visual fire alarm.

Care staff had access to a vehicle to enable them to drive people to social activities and for use on holidays. We saw risk assessments were in place for each person to safely use this vehicle, such as for an individual who had tried to leave the vehicle whilst it was moving.

Documentation relating to the management of risks was not always detailed enough to help understand how people were protected from avoidable harm. For example one person's support plan indicated they were at risk of falls and that they had a history of this. However, there had been no updates to their mobility

risk assessment in the previous two years and a care worker we spoke with said the person was usually steady on their feet unless they were rushing. We confirmed this during our observations on the day of the inspection. In addition although the person did not have a sensor mat in place in their bedroom, care staff indicated in their support plan the person was at risk of falling out of bed and so staff should ensure they slept in the middle of their bed and not on the edge. The person had a single bed and was not continuously monitored during the night, which meant it was not possible to fully prevent the identified risk.

We found there were risk assessments of the premises. These included Legionella risk assessments, fire safety checks, electrical and gas safety. Although the risk assessments were appropriately carried out, actions arising from them were not noted an acted on. For example, the fire risk assessment conducted on 27 June 2016 contained remedial actions. Although the provider had changed in April 2017, there was no action plan to check the risks were mitigated and the service had no record of communication with the landlord to organise the required works. A review of the fire risk assessment was required on 1 August 2017, but this was not completed. The Legionella risk assessment required some actions, and an external contractor completed the checks regularly. There were no records within the service of what checks were completed, except a folder with the date and signature of the contractor's staff. Some kitchen cupboards were not closing properly. This was not reported for repair. We also found that the fridge handle had snapped off and was not replaced. Instead part of the broken handle was screwed back on, making it difficult to open the fridge. Staff said this was reported for repair more than once, but were unable to provide information about when the provider would attend to this.

We spoke with the provider's health and safety coordinator as part of our inspection. They had commenced a few months before and were gradually implementing new systems for the premises and equipment risks. They explained and showed us two folders which would be used to store important information about premises risks. This included fire safety and we saw the registered manager had completed inserting information into one folder, and working towards completion of the second one. The health and safety coordinator explained this would help to ensure relevant information was available at the service-level, rather than only with the landlord.

People's medicines were mainly appropriately managed, but some improvements were required to ensure safety. We found medicines were correctly ordered from the local pharmacy and stored in the ground floor staff office. Fridge and room temperatures were checked and recorded by staff to ensure medicines were protected. Photos of people were in the medicines administration folder, but these were out of date and required renewal with dates clearly recorded on the photos. We checked people's medicines administration records and these were correctly completed. Codes on the charts were used when the person refused a medicine or was on social leave away from the service. Every person had a protocol for "as needed" paracetamol but this conflicted with the "homely remedy" paracetamol ordering. "Homely remedies" are medicines that can be purchased over the counter, such as painkillers. In addition, every person had a supply of paracetamol but there was a "homely remedy" supply also. This meant excess paracetamol was ordered and stored. There was a staff signature list, but this was outdated after staff had left and new staff had commenced. We saw creams were stored which weren't returned to the pharmacy in a timely manner. Accurate records were available of medicines returned to the pharmacy for disposal. Staff competencies were overdue and the registered manager agreed these needed to be completed again.

Fit and proper persons were employed at the service to support people. We checked an existing personnel file and found it contained the necessary documents required by the applicable regulation and associated schedule. This included proof of the staff member's identity, a full job history, checks via the Disclosure and Barring Service (DBS) and references. We noted that the agency worker profile forms did not contain all the necessary information required. We pointed this out to the registered manager who told us they would

contact the agency and ensure this was changed.

The calculation of staff deployment required improvement. We found there was no system in place to determine a safe level of staff for any shift. People did not have dependency assessments completed which could be tallied to determine the correct deployment of staff. We saw there were times when not enough staff were available to cover rostered shifts, and these were regularly completed by agency workers instead. Permanent care workers did complete additional shifts to fill gaps in the rotas, and were paid overtime accordingly. However in some cases we saw this had resulted in cancellation of their scheduled rest days, annual leave and dedicated training. Large volumes of staff annual leave had accrued, and although the registered manager was aware, they were not aware of the provider's policy. We viewed this with the registered manager and saw the policy allowed for "selling back" annual leave, and had rules about volumes of annual leave staff could accrue.

People who used the service were provided access to a local day centre each week, and staff accompanied them. Other people made visits to shops and cafes in the nearby community. Some people stayed in the building which meant at least one staff member remained at the service with them.

We recommend that the service develops and implements a method of determining safe staff deployment.

We spoke with two members of care staff about safeguarding. Both individuals demonstrated appropriate knowledge including who to contact if they were concerned about a person's welfare or needs. Staff also demonstrated detailed knowledge of people's safeguarding needs when they were out of the service in the community. For example staff knew which people had limited understanding of the risks of approaching strangers and had developed safety strategies when accompanying them to activities or on walks. There was a safeguarding and whistleblowing policy from the provider, which was outdated and did not contain information about how to report events within the host local authority area. We noted the staff office had a sign displayed which provided the contact details for the adult safeguarding team. This included out of hours contact information. We saw staff had received safeguarding and whistleblowing training.

Requires Improvement

Is the service effective?

Our findings

We saw each person had a diet and nutrition section in their support plan. Care staff used this to identify each person's likes and dislikes and to highlight where choking risks existed. We saw staff used food and fluid intake charts to ensure people received adequate nutrition and hydration where an unexpected change in weight was found.

Although there was evidence staff had been proactive in ensuring people had access to a community dietitian when needed, it was not evident specific diet advice was followed. For example, a dietitian had prescribed one person a Mediterranean diet to reduce the risk of pre-diabetes developing into adult-onset diabetes. The registered manager had provided information for staff on the Mediterranean diet in the person's support plan but there was no signature sheet to indicate if staff had read and understood this. On the day of our inspection, none of the meals the person was offered were in line with the dietitian's advice. We asked two care workers about this who told us the person was not on a special diet and had no specific nutritional risks. This meant the person's risk of developing diabetes was increased from the failure to follow the health professional's advice.

Although care staff completed weight charts for people who were at risk of malnutrition, they were inconsistent and did not always include reliable information. For example one person had two concurrent weight charts with entries during the same period. There was no documented reason for this and a care worker we asked could not explain it. This meant it was difficult to identify the person's weight changes or risk of malnutrition. For example, we saw there were three weight entries recorded between the two charts in a seven day period.

Each person had a health action plan that provided staff with a structure to record multidisciplinary (MDT) health professional visits and input. However, we saw this was used inconsistently. For example one person lived with a life-limiting condition. Although this was noted in their support plan, there was no information in the health action plan about how this was managed or if there was regular input from the MDT.

There were inconsistencies in the documentation of people's MDT care. This was because visits from health professionals were not satisfactorily recorded and the outcomes of visits were not always documented. Each person had a summary sheet of MDT visits but care staff did not always keep this up-to-date. For example, we saw one person's summary sheet indicated they had not been reviewed by an optician since May 2015. However an optician's certificate was in the support plan and indicated an assessment had taken place in August 2016. In addition a lack of detail and information from health professionals meant it was not possible to track people's health needs and how these were met. In another case, a person's support plan indicated they should have a podiatry review every three months but only three reviews were documented between October 2016 and September 2017. We found another instance where an audiologist had referred a person to their GP for care of their ear but there was no evidence this had occurred.

Staff turnover at the service was low and the newest member of staff had been in post for over one year. We looked at the recruitment and induction processes for this care worker as well as the support and training in

place for two more established care assistants. We found in each case care workers had completed a seven day induction period that included a skills needs assessment, four days of shadowing experienced staff and joint handovers with other staff.

Care staff undertook formal, documented supervision with a manager every three months that contributed to an annual professional development plan (PDP). However, from looking at staff records it was not always evident staff were given protected time to develop their PDP or that they were supported to identify appropriate training. For example one individual's record indicated there was no relevant training available to them. There was no documented follow-up to this from the management team.

We saw the provider set annual objectives for care staff and managers used the supervision process to measure achievement. However, when we checked the supervision records it was not always evident staff had access to the training they needed. For example, one supervision record noted the member of staff had repeatedly asked for more training in quality, but they were unable to access this. The records also showed mandatory training was not consistently kept up-to-date. We asked the registered manager about this and we were told about ongoing problems in staff accessing the provider's on-line learning system. This was also noted in the supervision record of another member of staff, who had been unable to access the system and so was not up-to-date with their training. Sixteen non-statutory specialised training modules were available to staff but in two personnel files we looked at none were completed. One member of care staff had completed additional specialist training in hoarding behaviours, data protection and first aid for people with mental health needs.

Although it was evident in supervision records that staff were able to raise concerns with managers, it was not always clear how these were acted upon. For example, one member of staff had raised concerns about how many hours they were working and how hard they worked. There were no documented actions from the management team in relation to this. We found the supervision records for one member of care staff included details of a person who used the service, including personal medical information. We checked this information with the person's support plan and found the information was partially inaccurate, which presented a risk to the member of staff and the person.

The management team used a skills profile to monitor each member of staff for up-to-date training. However it was not always evident this was maintained accurately or that care staff and managers knew if they were correct. For example one staff member's skills profile contained contradictory information to their personnel file. Training that was highlighted as needed in their supervision record was not documented as completed in their skills profile. In addition, the details included in the skills profile regarding dates of training did not match the certificates available for that individual. The training certificates available did not always provide evidence of the staff members' learning marked as completed. In one instance, we found a member of staff did not have certificates for their infection control, fire safety or safeguarding training. In the skills profile of another member of staff it was noted they had attended Mental Capacity Act 2005 training and moving and handling training but those certificates were not obtained. This meant it was not immediately clear if the staff member's training was current or what topics they had actually completed.

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. 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.

We saw evidence of signed consent in support plans for the delivery of care and the use of photographs around the home. Where a person did not have the capacity to sign their consent, this was completed by a family member instead. Staff documented each person's needs in relation to mental capacity and decision-making in support plans but there was no evidence of formal capacity assessments. Instead this information was based on input from the multidisciplinary (MDT) team, including a psychologist as well as their knowledge of each person. It was clear from looking at support plans where a lasting power of attorney was in place or where the court of protection was involved in a person's care.

A care worker coordinated and was responsible for ensuring applications were made in a timely manner and that the local authority DoLS team were notified of changes in a person's condition. We looked at the DoLS documentation for all four people with a pending application or authorisation in place. In each case a best interest assessment had been carried out with appropriate health professionals, including mental health advocates. Staff had been proactive in meeting recommendations or conditions made as a result of a best interest decision such as providing more opportunities to take part in social activities.

Pictorial menus were available and staff used these to improve choice for people who could not communicate verbally. However, these were not displayed on the wall in the dining room or kitchen. Similarly, pictures were not used in the kitchen to indicate to people what was stored within cupboards. We noted some people were independent and liked to enter the kitchen to make their own drinks and prepare simple foods. The addition of pictures to the cupboards would help people be more independent in ensuring their nutrition and hydration.

Good

Is the service caring?

Our findings

We saw from looking at the support plans of three people that staff were proactive in facilitating advocates for people. This included involving independent mental capacity advocates (IMCAs). IMCAs are impartial representatives used in important decision-making processes where a person has no family or significant others who can assist. Although there was evidence of advocate input, it was not always clear this information was fully shared with care staff. For example, an IMCA had noted in one person's mental health record that they were living with the psychological effects of a mental health condition. However this was not noted anywhere in the person's support plan, including in their health action plan.

We recommend that the service ensures information from advocates is included in care planning and review.

Support plans indicated staff worked with people to encourage them to maintain as much independence as possible. This included supporting people to safely prepare their own breakfast and to take care of their personal hygiene as far as possible. There was also evidence staff promoted independence in the communication section of support plans, which staff used to document how they encouraged people to make their own choices and to ensure they were given daily options.

Care staff encouraged people to take the lead on individual health and care issues where this was safe and appropriate. For example one person wore hearing aids and staff noted the individual was able to choose when to wear them and when to switch them on or off. However, they were unable to maintain the hearing aids and so staff carried out regular checks on them. Another person was able to choose their own clothes each day but needed help in choosing clothes appropriate for the weather and temperature. During our inspection we observed care staff help the person choose their clothes for the day based on what they planned to do and the weather forecast.

We observed care staff were skilled in ensuring people's dignity and privacy during our inspection. For example when one person wanted to make tea in the kitchen in their nightwear, so staff gently encouraged them to get dressed for the day first and then promised to bring them back for a drink.

People's confidential personal records were protected. We saw all office computers used for recording information were password-protected and available only to staff with the appropriate access. Paper records of care were maintained, but where these existed they were locked away so that there was restricted access to staff only. Staff records or documents pertaining to the management of the service were also locked away. In some instances, where there was sensitive information, the records were only accessible by the registered manager or provider.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 (DPA) requires every organisation that processes personal information to register with the ICO unless they are exempt. This ensured people's confidential personal information was appropriately recorded, handled, destroyed and disclosed according to the legislation.

Good

Is the service responsive?

Our findings

Care staff had worked with people and their relatives to document their preferred daily routine. This included what time they usually liked to get up and go to bed. We saw daily plans included detailed personal information used to help ensure people felt at home, such as one person who liked to keep a teddy bear on their bed.

Although support plans were detailed in relation to people's social needs and activities, they were not always updated in a timely manner. For example one person's support plan included a note from November 2014 that indicated they spent most of their time in their bedroom and had stopped taking part in social activities. However a member of care staff had noted in February 2017 that the team was to encourage the person to exercise by moving around the home. The individual also took part in weekly games and other social events at a day centre to reduce the risk of social isolation. From our discussions with two care workers and the registered manager it was clear staff had a detailed understanding of this person and their needs and personality but this was not evidenced in all parts of the support plan.

During our inspection we observed examples of personalised care delivered by care assistants who had a demonstrable understanding of each individual. For example we saw a care assistant sit with one person and help them to use a colouring book.

We saw the service was decorated with photographs of social activities that people and staff took part in. People helped to create the photo displays and we saw from looking at support plans that this was part of the activities provided for people who enjoyed arts and crafts. The photographs showed a range of activities in which people were clearly socialising and having fun.

We saw from looking at support plans that staff worked with each person to ensure they were individualised. For example, each support plan included an "all about me" section and a photograph used with consent. We found this document was a personal narrative of each person's life and we saw staff, family members and friends had helped to complete them. The narratives included each individual's likes and dislikes as well as information on what was important to them, such as holidays and being able to see their friends. The support plans we looked at included a wide range of activities and hobbies people enjoyed, such as playing the drums, trips to the seaside and farms or agricultural environments.

We found a significant focus on individual needs in support plans based on the detailed knowledge staff had of each person. For example, one person experienced anxiety that their relatives would not visit them due to their past history. Staff had identified ways to reduce this anxiety and help the person enjoy visits from their relatives without being preoccupied by worry that they would not return. Care workers had achieved this by working with the person, their relatives and a previous care provider who knew the person well.

The staff team ensured people had access to resources to take part in activities and hobbies that were important to them. This included ensuring art supplies were always available and working on the garden so that people could enjoy the sun and private outside space.

Staff supported people to maintain a meaningful social life. For example, each person had a section in their support plan titled "people important in my life." This included the use of photographs, with documented consent, and details of the relationships that were of value to them. In addition a range of activities were routinely available to help people spend time with their friends and socialise, including visits to cafes, pubs, garden centres and communal meal times. Care staff maintained a weekly schedule for each person and we saw this included a wide range of activities that met their social and health needs. Care staff we spoke with demonstrated detailed knowledge of each person's activities schedule and their likes and dislikes. For example, one member of staff took three people to a local pub and knew their favourite drinks and where they liked to sit.

The service ensured that people had access to the information they needed in a way they could understand it and were compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place by the NHS from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Each person had a detailed communication, self-expression and understanding section in their support plan. This was used alongside their ability to consent to care to help staff understand the best way to communicate with them. For example if a person could speak but needed encouragement at times, staff documented the best way to help them express themselves. Staff had documented guidance based on their experiences with each person and their understanding of individual needs. For example they knew that when one person because agitated or upset, they could effectively comfort them by taking their hand and having a calm conversation.

Care staff used pictorial signs to support verbal communication when needed and some people could communicate using Makaton (a type of sign language for people with learning disabilities). Communication support plans were personalised and care staff had documented how they supported people to develop their communication skills. For example they had worked with one person to encourage them to shake the hand of new people they met rather than hug them, to protect them from the safeguarding risks associated with touching strangers. In addition the care team had worked with them to normalise polite vocabulary such as using "please" and "thank you" more regularly.

Each person had a hospital 'passport' to be used in the event they had to attend hospital as an inpatient or were taken to an emergency department. The passport used the 'red, amber, green' system to highlight important information to hospital staff such as regular medicines and existing health conditions. It also included personal and social information to help them communicate such as how the person liked to be addressed or possible causes of anxiety.

We checked what systems were in place at the service to routinely listen to and learn from people's experiences, concerns and complaints. The registered manager had prepared a new survey for relatives of people who lived at the service but this had not yet been issued at the time of our inspection.

The registered manager or a care worker facilitated a meeting each week for people who lived in the service. A member of staff recorded notes for each meeting and we looked at the notes from the ten meetings prior to our inspection. We found staff encouraged people to talk about what they liked about the service as well as give feedback on things they wanted improved. For example, one person had said they didn't like their mattress and staff had provided another one for them. People consistently commented on how much they enjoyed weekly activities, including visits to a summer fayre and a wildlife park.

A complaints policy was in place but this was not on display in the service, which meant visitors could only

access it if they asked for it. A copy of the complaints procedure was available in pictorial format but this was stored in the complaints folder and was not readily accessible to people or visitors. There was a suggestion box, but it was unclear who the suggestion box was designed for and how it was used.

We recommend the service implements a robust system for managing concerns, complaints and compliments.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, the registered manager was registered to manage two of the provider's services, both within a short distance of each other. At the other service, a deputy manager was in post and able to help oversee the service in the registered manager's absence. At 5 Winston Court, the deputy manager had left their post, meaning there was no backup from a senior staff member at that location. We were told recruitment was underway for a new deputy manager. The home manager from a third service under the provider's registration was on annual leave, and the registered manager at 5 Winston Court was expected to additionally oversee that service. The registered manager was required to be on call for the services, deal with staff vacancies, cover any shift shortfalls, attend important meetings and events and ensure the safe operation of all three services at the same time. Although the registered manager had good support from their line manager, the contemporaneous management of three services over a short period was unsafe. We found other options were available from within the provider's own group of services that could have supported the short-term management of the third location.

The registered manager demonstrated a clear knowledge of their responsibilities and people's needs. However the systems in place to monitor and support the provision of care were not always clear. Changes between the providers of the service had resulted in confused operational systems at the service level, for example policies and procedures. The fundamental monitoring and evaluation of staff and systems remained unchanged and the new provider had not implemented their own systems in the service. We found limited written evidence and some gaps in knowledge regarding the tools for evaluating and improving the service.

We found multiple policies from the provider were not reviewed or out of date. The registered manager had printed the policies and placed them in folders for staff to read. However, staff time was used providing support to people. This meant they had little time to read the policies, check for updates or understand the content and ask questions. We checked what systems the service used to monitor the safety and quality of the service. Despite registering in April 2017, these had not changed since the provider had taken operational responsibility for the service. Some were not fit for purpose, contained sparse or irrelevant information and where deficits were found, these were not actioned or carried forward to the next audit. This meant the information from audits and checks was not used to ensure compliance and gauge the safety and quality of care.

The most comprehensive audit that occurred was titled "CQC evidence checklist" and usually completed monthly by another service's manager. We saw this was based on "outcomes 1 to 21", which were part of prior legislation we inspected under from 2010 to 2014. Some prompts from the new regulations, key lines of enquiry and key questions were missing. This meant new standards of safe and quality care were not incorporated in the tool. However, the audit did contain some subjects still relevant under current regulations. These included person-centred care, medicines, assessing and monitoring the quality of the service and equipment. We looked at the last audit dated 15 August 2017. The audit contained little information as to what was checked, with some of the areas checked left incomplete or blank. Where areas of good practice were found from the audit, these were appropriately noted. Where areas for improvement

were required, these were also documented. The tool had two columns for an action plan. The actions required to improve the service were not always adequately worded, timeframes for completion were too broad or unrealistic and a staff member responsible for the actions was not listed.

Audits of people's care files such as risk assessments, care plans and reviews of the care documentation were not robust. Checks of the content of staff personnel files were not completed. A health and safety audit was regularly completed. An infection control audit tool was available and completed. This was a simple 'tick list' with reference to some basic features of infection control and prevention. We looked at the results from the audit completed prior to our inspection. We noted the audit contained information about call bells and chemicals (CoSHH), lifting equipment operation and portable appliance testing. These are not areas routinely checked in an infection control audit. The audit was not aligned with, and had not considered the key aspects within the Department of Health code of practice for infection. This contradicted with the provider's infection control policy which stated, "This organisation adheres fully to the (DoH) code of practice and associated guidance." This meant the audit completed by staff missed areas normally inspected within infection control checks.

A service improvement plan was in place at the service. This recorded various actions identified from different audits and checks. This also logged areas that the service needed to improve. When we checked, the plan was outdated and was created prior to the new provider operating the service. It was not clear which actions were ongoing and any that were completed.

There was a lack of consistency in the care documentation we looked at between people. For example, we looked at three support plans and found staff had used different templates and forms in each one. Although critical information was in place in most cases, the lack of consistency meant it was not always clear how often care information had been updated or whether it was still relevant. This was because some documentation had been issued by previous providers or other healthcare organisations.

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

Accidents and incidents were reported and recorded by staff. However, these were stored in people's individual care folders. Although this was satisfactory, it was difficult for the registered manager to gauge the number of incidents or accidents, as no central log was maintained to record all of the reported events. The number of reported incidents and accidents was low, and this meant it was not possible to identify any themes or trends by looking at these.

The service was required to have a statement of purpose. A statement of purpose documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. The statement of purpose was available in the reception area for members of the public to view if they desired. An easy-read version for people who use the service was not provided. The document was not updated and contained incorrect information. We pointed this out to the registered manager who agreed to liaise with the provider and have the statement of purpose updated.

Staff we spoke with explained that they were satisfied with the workplace culture at 5 Winston Court. They felt well supported by the registered manager, although they explained the loss of the deputy manager had impacted their ability to have a management team member in the service some days. Staff told us they got along well as a team and enjoyed supporting the people who used the service. We found staff were approachable and knowledgeable.

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 17 HSCA RA Regulations 2014 Good governance The registered person had not established an effective system to ensure compliance with regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not always take mitigating action where audits, monitoring and assessment systems identified risks relating to the health, safety and welfare of service users and others.