Ordinary Life Project Association(The)

Ordinary Life Project Association - 56 Sycamore Grove

Inspection report

56 Sycamore Grove
Trowbridge
Wiltshire
BA14 0JD

Tel: 01225763056

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

56 Sycamore Grove is a care home for three people with learning disabilities. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This is the first time this service has been given an overall rating of Requires Improvement. At the previous inspection dated November 2015 we rated the key question Safe as Require Improvement. We found that risk assessments were devised over significant periods of time which the registered manager had signed annually as ongoing. Action to improve this key question from Requires Improvement to at least Good is now required.

This inspection took place on the 28 February 2018 and was unannounced.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy

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.

Quality Assurance systems were in place, but areas identified as requiring action had not been prioritised or completed. The registered manager had self-assessed how set outcomes were being met. We saw the registered manager had indicated that all standards were met in the self-assessment, dated December 2017. Action plans were devised and included "re-formatting" care plans, having keyworker meetings, assessing staff competency with medicines and developing questionnaires to relatives. The area manager had conducted an assessment of the set outcomes in January 2017 and had recorded "plan to review and re-write care plans". While we acknowledge the staff and people went through a period of instability, no action was taken in relation to "re-formatting" care

Although people's records were securely stored, they were not complete or up-to-date. Risks assessments were devised over a significant period of time, which the registered manager signed and dated to indicate they were reviewed annually. At the inspection of November 2015, we said "where risk assessments were in place they had been devised over a significant period of time" and were not updated in that period. While the risks identified may be ongoing, there was little consideration given to changes of legislation and good practice that have occurred in the meantime. This meant no action had been taken to improve the guidance to staff on how to minimise risks.

The staff we spoke to were knowledgeable about people's individual risks and the actions needed to minimise the risks. Individual risks to people included self-harm risk of malnutrition and mobility impairments. Some risk assessments lacked detail and were inconsistent with information held in care plans. For example, the risk assessment for one person with a mattress monitor was missing.

There were people who expressed their anxiety and frustration using aggression. Staff told us and training records confirmed that staff had attended positive behaviour management training. For one person there were a number of behaviour management strategies which had been devised over ten years and had been reviewed annually as current. Risk assessments were not reviewed although the person had continued to express their anxiety and frustration. Strategies were not reviewed to assess that appropriate action was being taken to minimise the risk of self-harm to the person.

Care plans did not fully reflect people's physical, mental, emotional and social needs. The agreed outcomes specified within social workers comprehensive care plans were not used to develop care plans with the person. Where care plans were in place, they lacked people's preferences on how their care was to be delivered. For some people, care plans were developed over a significant period of time which the registered manager had reviewed annually as current.

People's life stories were not part of their care plans, which meant there was little information about people and their family, education, hobbies and interests.

Incidents and accidents were reported, however there was no overarching view of patterns and trends. The registered manager said copies of these reports were analysed by the provider. They said action was taken where further action was advised from senior manager. The registered manager said the reports were then filed in care records.

The safety of communal and personal spaces and the living environment were regularly checked to support people to stay safe.

Steps were taken to ensure medicine systems were safe. People told us staff administered their medicines. Staff told us and training records confirmed staff's competency to administer medicines was assessed. Medicine administration records (MAR) charts were signed by staff to indicate the medicines administered. Where "as required" also known as (PRN) medicines were prescribed, protocols were devised on the administration of these medicines. Some protocols lacked detail on the signs and symptoms that indicated PRN medicines were needed. This meant that the PRN protocols did not guide staff on how to recognise when people might need these medicines.

People told us the types of day to day decisions they were able to make. The staff told us and training records confirmed they had attended Mental Capacity Act (MCA) training. The staff we spoke with were knowledgeable about the day to day decisions people made. These staff also confirmed that people were accompanied in the community.

Mental capacity assessments had not been completed for care and treatment which meant the applications for Deprivation of Liberty Safeguards (DoLS) were not within the principles of the MCA. There were inconsistencies with the assessments of capacity for specific decisions. For example, a mental capacity assessment was in place to reduce calorie intake for one person but when the same person refused to follow specific diets for their medical condition a capacity assessment of this complex decision was not taken. The registered manager told us urgent DoLS applications for continuous supervision were made some time ago. However, copies of the application were held at the provider's office and not held at the home.

The safeguarding processes in place ensured people at the service were protected from abuse. Members of staff told us and training records showed safeguarding of abuse training was attended. The people we spoke with said they felt safe and the staff gave them a sense of safety.

Staffing rotas were designed for two staff during the day and one member of staff lone working from 5pm onwards. The member of staff lone working also slept in the premises. People told us they received assistance from the staff as required.

The staff were supported to develop the appropriate skills and knowledge needed to meet the needs of people accommodated. The training records reviewed showed that staff had attended training which the provider had set as mandatory. One to one meetings with the registered manager were regular to discuss performance, personal development needs and concerns.

People participated in menu planning. There was a range of fruit, vegetables as well as tinned and dried produce.

People were aware care records were held. They said there was one to one time with their keyworker. People's views about the service were gathered. We saw "your views" forms that were in picture and word formats were used to gather people's feedback about their meals, places to visits, staff and activities.

There were opportunities for people to participate in community activities. People with religious beliefs were supported to visit places of worship and to join clubs, activities and trips organised by Christian groups.

The staff were knowledgeable about the aims of the organisation. They knew how these values were embedded into practice. Staff told us the team was stable and they worked well together. They told us the registered manager was approachable. Staff received feedback through regular team meetings where discussions about people, information were shared and roles and responsibilities discussed.

Staff supported people when they became distressed and responded to requests for support and assistance. Staff knew people's preferences and how to approach people in a sensitive manner.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 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 safe.

Records were not up to date.

Risks were identified but action plans were not in place for all risks. Action plans were not detailed on how staff were to support people to take risk safely and to minimise risk. Members of staff were knowledgeable about the risks.

People said they felt safe. Staff had attended safeguarding adults training and their comments indicated they knew how to recognise the types of abuse and their duty to report their concerns.

Medicine systems were mostly safe. Staff had signed medication administration records to indicate the medicines administered. Procedures on the administration of when required medicines were not detailed.

There were sufficient staff to support people during the day .

Is the service effective?

Requires Improvement

The service was not effective.

The principles of the Mental Capacity Act 2005 were not followed. Where people had cognitive impairments mental capacity assessments were not completed for complex decisions. People were subject to continuous supervision and their liberty restricted from leaving the home. Deprivation of Liberty Safeguards applications were made before mental capacity assessments were completed.

The staff had attended training relevant to the needs of people at the service. One to one meetings with the service manager were organised to discuss performance, concerns and training needs.

People were supported with their ongoing healthcare needs and with their nutrition and hydration.

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Is the service caring?

Good

The service remains Caring.

Is the service responsive?

Requires Improvement

The service was not Responsive

Care plans were not person centred, the effectiveness of the action plans were not monitored and they were not updated following changes in people's needs in line with good practice.

People were supported to take part in activities that were relevant and appropriate to them.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance arrangements were not always applied consistently.

Staff were aware of the values of the organisation and said the team was stable and worked well together.

People's views about the service were gathered.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 28 February 2018 and was unannounced. At the time of the inspection there were three people accommodated.
Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection was completed by one inspector. We spoke with the two people, three members of staff, the registered manager and the Residential Services Co-Ordinator. We looked at documents that related to three people's care and support and daily records. We also reviewed staff's training records, duty rosters, organisational policies and procedures and quality monitoring documents.

Requires Improvement

Is the service safe?

Our findings

The staff were knowledgeable about the risks to the individuals and the actions needed to reduce the risk. However records were not up to date or accurate. Risk assessments were devised over a significant period of time and no action to update the risk assessments was taken since our previous inspection in 2015. The registered manager had signed copies of the risk assessments annually to indicate they had been reviewed and were ongoing. While the risk may be current there was no consideration for changes in person's needs, changes in legislation or changes in good practice guidelines.

Risk assessments were in place to support people to take risks safely. For example, prepare refreshments, traveling in the home's vehicle and to access community facilities. However, risk assessments lacked detail. The moving and handling risk assessment for one person was dated 2012 and stated the overhead hoist in the bathroom was to be used for transfers. This person was able to operate the hoist with staff supervision which the registered manager had signed annually as reviewed. We noted there was an overhead hoist in the bedroom and a member of staff told us this hoist was no longer used. There was no documented information on how the person transferred to bed.

We observed two people using walking aids. However, risk assessments were not in place to explain the support needed from the staff. A member of staff told us one person did not need any support with standing and was independent with walking. Another member of staff said they walked beside people that used walking aids. The registered manager told us that emerging risks were reviewed.

Bed monitors were used to alert staff when the person was having a seizure. For one person at risk of seizures, the risk assessment did not include the details of the monitoring aids used. The risk assessment included a description of the seizures experienced and the care to be delivered. This meant that the action plans were not clear on when monitors were to be used and the impact this had on the person.

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

Some people expressed anxiety and frustration through aggression. Staff told us and training records confirmed they had attended positive behaviour management training. A member of staff told us when one person became "agitated" they used distraction techniques which included offering explanations and refreshments. For another person staff gave them "time" as "too much confrontation" increased the levels of aggression. Another member of staff said when one person was showing "early signs of distress" the staff safeguarded other people from potential harm. They said the person was offered medicines to reduce "agitation".

For one person a strategy to reduce potential conflict with others was initially devised in 2008 and had been reviewed annually as current. It was recorded in 2010 and in 2012 that there was "liaison" with a behaviour nurse. In 2014 there was a team meeting with staff and the behaviour nurse to "explore the behaviours" of this person. The potential triggers and the strategy for staff to follow were recorded within the minutes of the

meeting. Strategies had not been updated following the input from the behaviour nurse in 2010 and in 2012 or on the triggers identified at the meeting in 2014.

The antecedent, behaviours and consequence (ABC) charts for this person indicated there were ten incidents of difficult behaviours between January 2018 and February 2018. These incidents included episodes of self-harm and allegations to harm others. The triggers identified included being short staffed. Staff then used distraction techniques to prevent situations of aggression from escalating. The staff told us triggers included having agency staff and visitors to the home. During the inspection we observed an incident where the person was self-harming and the staff established the person was experiencing pain. We observed the person being offered and accepting pain relief. Strategies in place were not reviewed following each incident and had not been updated. For example, pain may be a cause of the self-injurious behaviours.

Some people were prescribed with medicines to be taken when required also known as (PRN). The procedures for PRN medicines lacked detail. For example, for one person prescribed Lorazepam, the PRN protocol stated "for high levels of anxiety". For another person an inhaler was prescribed and the protocol stated the purpose of the medicines was to "relieve shortness of breath" and was to be taken four times daily. The symptoms to look out for and when to offer the medicine were not detailed in the protocol and this meant there could be inconsistencies in when staff administered medicines. Where PRN medicines were prescribed for pain, the protocols lacked detail. For example, whether the person was able to ask for the medicine or if they need prompting or observing for signs of need, for example non-verbal cues.

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

Fire risks assessments detailed the checks carried out to ensure the safety of the living environment. There were weekly fire alarm systems checks, monthly checks and annual servicing of emergency escape lighting and of fire extinguishers. Fire Safety procedures in place gave staff guidance on how to support people to evacuate the property safely and also included were emergency contact numbers.

Medicines were mainly safe use of medicines. People told us the staff administered their medicines. Staff told us and training records confirmed they had attended medicine training. A member of staff told us there had been medicine errors in the past. Another member of staff said some medicine errors were made by agency staff. The registered manager said medicine errors related mainly to "omission and stringent checks" were in place to ensure medicines were administered and records were signed to show when medicines were administered.

People's individual medicine administration records (MAR) were kept in the medicine files with a photograph of the person to ensure staff recognised the person and essential information, such as known allergies. MAR charts were signed by the staff to indicate medicines were administered according to their prescription.

Incidents and accidents were documented. Staff told us they reported accidents and incident which the registered manager investigated to ensure appropriate action was taken. The registered manager said accident and incident were analysed by senior managers. They said action was taken where senior managers had advised and documented before the reports were filed in the appropriate care record.

Safeguarding systems, processes and practices were developed and implemented to safeguard people from abuse. The people we spoke with said they felt safe and the staff gave them a sense of safety. Staff told us

and the training records confirmed they had attended safeguarding from abuse training. These staff knew they types of abuse and were aware of their responsibility to report allegations of abuse.

There were sufficient numbers of suitable staff to support people to stay safe and meet their needs. The registered manager said there had been a period when agency staff was used but this was no longer happening regularly. People told us there was enough staff on duty and they gained the assistance needed from staff as requested. Staff told us during the week the staffing levels were two on duty during the day. They said after 5pm and at weekends there was lone working. One member of staff said where there was lone working and activities were organised additional staff were rostered to work

Requires Improvement

Is the service effective?

Our findings

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 told us they made decisions about their meals, activities and times to rise and retire. The staff told us and training records confirmed they had received MCA training. While members of staff were knowledgeable about the day to day decisions people were able to make mental capacity assessments for care and treatment were not completed or recorded accurately. The records viewed indicated that people had cognitive impairments and were not able to make complex decisions. For one person the social workers care plan stated "would likely need support of the mental capacity for complex decisions". For another person the psychiatrist had documented in a letter "regarding consent XX lacks capacity to consent to care and treatment". Despite the registered manager making authorisation requests to the local authority, to deprive people of their liberty, mental capacity assessments were not undertaken. Best interest decisions were not completed for people who were subject to continuous supervision, to restrict their freedom and prevent them from leaving the property unsupervised. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A mental capacity assessment dated 2010 was in place for one person around their "calorie reducing meal intake" diet. The registered manager signed and dated the assessment annually to indicate it was current and ongoing. It had been documented that the person had "verbally agreed" and there was a dietician input received in 2013. The best interest decision was unclear and input from the dietician was not part of the assessment.

For another person, a risk assessment dated July 2017 included advice from a healthcare professional regarding a drinking receptacle that may be used to harm others. We saw recorded in August 2017 where the healthcare professional had stated that a best interest meeting was to take place regarding the risk if the person refused to use alternative drinking receptacles. A mental capacity assessment was not completed for this.

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

People were involved in decisions about what they eat and drink. People confirmed they were involved in planning of their meals. One person told us they were able to prepare refreshments. A member of staff told us people participated in menu planning. They said books with pictorial meals and food items were used to help people plan meals. We saw menus were on display in the kitchen and included the main meal of the

day. We saw a wide range of tinned foods, cereals fresh vegetables and fruit which supported the menus in place.

Risks to people with complex needs in relation to their eating and drinking were identified. However, care plans were not detailed on the support needed with eating and drinking. For example, the nutritional care plan dated 2014 for one person stated their "weight fluctuated". There was fortnightly monitoring of their weight and staff were instructed to contact the GP if their weight was to be below a specified range. The GP records for December 2017 confirmed the person had continued to lose weight below their weight range and supplements were prescribed. The care plan was not updated to include the supplements prescribed and on how to manage persistent weight loss. The person was on a lower sugar intake diet; however, there was no indication a referral to a dietician was requested.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014"

New staff received an induction on their role and on the people they were to support. A member of staff told us their induction was "good" and prepared them for their role. They said their induction included shadowing more experienced staff and undertaking the Care Certificate (set of standards that health and social care workers adhere to in their daily working life).

There were arrangements in place for staff to maintain their practice and knowledge. Staff told us they must attend training set by the provider as mandatory. A member of staff told us they were informed about training updates which were held at the service and at head office. The 2017 training plans showed staff had attended positive behaviour support, first aid and epilepsy training.

One to one meetings between staff the registered manager took place regularly. A member of staff said one to one meetings were three monthly and discussions were based on their roles and responsibilities, and about issues or concerns.

People were supported to access healthcare services and receive ongoing healthcare support. Health action plans in place detailed the support received by people from healthcare professionals with their ongoing health. Records of healthcare professional visits indicated people had regular dental and optician check-up and visits from chiropodist.

Profiles and emergency management plans were in place for one person with epilepsy. Within the profiles the information included the types of seizures, the assistance to be provided by the staff and the aids and equipment used. The plans were reviewed in 2017 by a healthcare professional and stated the frequency of seizures had increased and monitors were used to alert staff when the person was having a seizure.

People's individual needs were met by the adaptation, design and decoration of premises. The property had the appearance of a domestic dwelling which blended well with the community. Communal spaces were on the ground floor with bedrooms on the ground and first floor. Bedrooms were single and people's interests and hobbies were reflected in the décor and by their personal belongings. For example, photographs of friends and family, and pictures of singers and collections of cars.

Good

Is the service caring?

Our findings

People told us the staff were kind to them. The staff were aware that people needed to feel that they mattered, were listened to and information was presented in way that was understood. A member of staff said "we listen to people's views. The "tone of and the approach" made people feel they were important to staff. They said "some people liked a laugh" and one person enjoyed to "banter" with the staff. Another member of staff said they had an understanding of people's preferences and spoke to them in a way they understood. They said care plans helped them gain an insight of people's preferences and on how people communicated. For example, one person responded with "yes and no".

The registered manager told us how they ensured people were treated with kindness and compassion. The registered manager said through induction and one to one meetings, they ensured staff were working within the values of the organisation. The registered manager also said they "worked directly with staff and able to give feedback on their [staff] practice."

We saw staff show concern for people's wellbeing and responded to their needs quickly. When one person became distressed we heard the staff use a sensitive and soothing approach. The staff established the cause of the distress and offered medicines to relieve their symptoms. We saw staff discreetly move people from the vicinity to protect them from potential harm.

People were cared for with compassion. A member of staff said one person had experienced a bereavement of a much loved close relative and staff had made referrals for bereavement counselling. This member of staff said, "Staff make time to talk about the bereavement of [people's] loved ones". We saw information documented on how staff were to support people that had experienced bereavements. For one person, tributes which celebrated the life of a loved one were kept in their care records.

We also observed staff supported people with their meals. A member of staff told us it was important to maintain a calm atmosphere during the evening meal. They said this helped people to relax and become calm before they retired for the evening.

There were opportunities for people to have one to one time with staff. A member of staff told us a keyworker was assigned to work with specific people. They said the keyworker role included one to one time with people to gather their views, organise activities and healthcare appointments. People told us they had a keyworker and spent time together.

"Your Views" questionnaires were in picture and word formats and were used by keyworkers to gain people's feedback on meals, activities and about people that mattered to them. For example, one person expressed that they liked the food, enjoyed trips to Devizes and Weymouth and "liked the staff".

People's rights were respected. People told us staff knocked on their bedroom door before entering. They said they had a key to their bedroom. A member of staff gave us examples on how people's privacy and dignity was respected. For example, making sure doors were closed during personal care. Another member

of staff said "you go with their choice and what they want."

Requires Improvement

Is the service responsive?

Our findings

Although care plans reflected people's physical, emotional and social needs their preferences, likes and dislikes were not included. Life stories that can enhance people's identity encourage better communication and an understanding of their wishes were not gathered. For example, details of family relationships, education and employment history as well as interest and hobbies. This meant information from life stories was not available to develop person centred plans. One person was aware that a care plan was in place and kept in the office.

The personal care plan for one person lacked detail, their preferences were not included and the language used did not protect their dignity. While their personal care plan listed aspects of care they were able to manage it was recorded that "personal hygiene is poor" and was "reluctant to wash their hands". Although documented that the "support plan has been sensitively discussed with the [person] on a one to one basis". The additional "Daily Bath" care plan gave staff guidance that "if [person] refuses to bathe avoid being drawn into reasons say simply just ONCE If you don't have a bath I will have to let people know". Under behaviour support note of the personal care the registered manager had recorded that repeated requests to undertake personal care was a trigger of increased "agitation". However, this was not recorded in the behaviour management plans.

The effectiveness of the action plans were not monitored or recorded and care plans were not updated for significant periods. The personal care plan for one person was initially devised in 2012 and reviewed annually by the registered manager as ongoing. For another person the communication care plan was devised in 2008 and was signed annually by the registered manager as ongoing. Although the needs identified may be the same the effectiveness of the action plans were not monitored. This meant care plans were not updated following reviews of the action plans or consideration given to changes in good practice and in legislation.

Communication care plans were in place and identified people's communication needs with guidance on how information was best delivered. Care plans had not been updated since the introduction of Accessible Information Standard (AIS). A legal requirement passed by Government in 2016 to ensure that people with a disability or sensory loss services received information in a way they can understand. For example, the communication care plan for one person dated 2013 stated "written information can be enhanced with the use of symbols and pictures. It is important to present clear simple text and symbols using numbers not words." However care plans were not in pictures and symbols format. The staff were to support one person with improving their communication skills. This care plan had been developed since 2008 and meant this person had been learning Makaton for ten years. However, there was no evidence of this happening or that the action plans were monitored for their effectiveness.

"This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014"

Some steps had been taken to share information using picture and words formats such as, feedback about

the services, locking bedroom and about people's preferences with hygiene routines. Other formats in pictures and words included complaints procedures and tenants meetings. A member of staff said care plans were "fine", they read them and all information needed to deliver care and treatment was included. They said the registered manager developed the care plans and keworkers (staff assigned to work with people) ensured all required information was held in the care files. Another member of staff said there were team discussions on changes of people needs. They said "everybody [staff] knows what is what and maybe it's not written down. It is in the individual diaries." The registered manager said "I would like to radically change the care plans". They said the focus for this year was to updated the care plans with keyworkers.

Handovers of information occurred daily and when there were shift changes of staff. A member of staff said staff completed handover "sheets" to ensure checks and routines had taken place. For example, checks of medicines. Individual diaries were used by the staff to record direct care delivered, activities undertaken and meals served.

People were supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them, including in the wider community. Where appropriate, people had access to education. During the inspection we observe a keyworker with one person going out for coffee. This keyworker said they accompanied the person on trips to cafes and on shopping trips. They said they also took the person to college.

Activity planners were kept in bedrooms and the people we spoke with told us about their activities and how they spent their day. One person told us when they were home they watched TV, DVD's and listened to music. This person said they attended college courses, they had visits with relatives and they had recently bought a pet rabbit. Another person told us they joined Christian groups who organised outings and staff accompanied them on trips to cafes and they participated in exercises.

The people we asked knew how to make a complaint or raise concerns. People told us when they were "unhappy" they told the staff. Copies of the OLPA complaints procedure was included in people's care records. The registered manager told us no complaints were received since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post and there were visits from senior managers. The staff said the registered manager was "professional and approachable". They said the team worked well together and resolved conflict quickly and in constructive manner.

Systems to assess and monitor the delivery of care were in place. However, there was little evidence that improvements had taken place in a timely manner. The registered manager assessed set outcomes and indicated in the self-assessment (dated December 2017), that all outcomes were met. The actions from the assessment were based around having keyworker meetings, medicine competency training for staff, developing questionnaires for relatives and "reformatting" care plans. The Residential Services Co-Ordinator had completed a manager's self-assessment in January 2017 and the actions included "plan to review and rewrite care plans and all "staff received a training plan". We noted during the inspection that care plans and risk assessments were not updated for a significant period of time. This meant quality assurance arrangements were not always applied consistently.

In the self-assessment dated January 2018 the registered manager had indicated that "care plans are discussed and signed. Relevant care plans are in place to meet expected outcomes. Evidence of seeking service user consent in files." One action detailed in the action plan was to introduce personal development plans for staff, staff's medicine competency and developing relative's questionnaires. This meant priority had not been given to assessing the effectiveness of the care plans and on updating them to reflect changes in good practice or in legislation.

There was some learning from incidents investigations, but an overview of these events was not in place. The registered manager told us and staff confirmed that accidents and incidents were reported. These reports were analysed at provider level, further action was taken as required from senior managers then filed into the individuals care records. This meant the registered manager was not able to consider from the overview if any lessons could be learned and changes to care practices made.

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

The staff were knowledgeable about the values of the organisation and knew how they were embedded into practice. A member of staff told us "people have a great life. It's a lovely home and lovely staff. People are helped to maintain contact with relatives. People have access to the community. If people have a problem they will communicate it." Another member of staff said that OLPA stood for "normal as possible. Staff are here to support people to live as they would in their home. It's like living in their own homes."

Arrangements were in place for staff to receive feedback from managers in a constructive and motivating way, which enables them to know what action to take. Staff meetings were regular and the minutes showed staff discussed the actions from previous meetings and guidance from other social and healthcare professionals was discussed. A staff meeting was organised on the day of the inspection. We saw all staff

attended including those that were off duty and the residential services co-ordinator.

There was open communication with people and those that mattered to them. The registered manager told us that house meetings with people were to be reinstated. We saw copies of "Your voice" questionnaires in pictures and words used to gain feedback from people. The registered manager told us relatives questionnaires were sent in January 2018 but relatives had not returned them as yet.

There were regular visits to the service by senior managers. The report of these visits (dated August 2017), stated the focus of the visit was the property and administration and maintenance staff took responsibility of the visit. In December 2017, a visit had taken place by the local authority and their visit report detailed the areas reviewed. We noted there were no recommendations from this visit.

A visit from Wiltshire Dorset Fire Rescue occurred on 3/04/2018 and accurate records were found in regarding fire training, checks of alarms and systems and staff attended practices and drills.

The registered manager recognised continuous improvement was needed to manage future performance. They said at team meetings incidents and accidents were discussed for learning opportunities. Staffing was stable and senior managers said they were "proactive in retaining staff". Potential staff were offered an opportunity to experience working in a caring environment. The organisation offered staff progression opportunities. There were plans to "look for opportunities for people to participate in local clubs." to build upon their interests.

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 9 HSCA RA Regulations 2014 Person-centred care People's preferences, their likes and dislikes were not part of their care plans. Their life stories were not gathered. Care plans were not updated or their effectiveness monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were not completed before applications of Deprivation of Liberty Safeguards. Where people had cognitive impairments capacity assessments were not undertaken for complex decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not up to date and lacked detail on how to minimise the risk. Some risks had not been identified and action were not taken on minimising the risk. Behaviour management plans did not have information on the triggers on signs of anxiety and frustration. These plans were not reviewed following incidents of aggression. When required medicine procedures lacked

detail on when these medicines were to be administered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance arrangements were not always applied consistently. Areas of improvement identified were not the prioritised and completed. Records were not up to date or accurate.