The Royal School for the Blind

SeeAbility - Fir Tree Lodge Residential Home

Inspection report

Fir Tree Lodge
Heather Drive
Tadley
Hampshire
RG26 4QR

Tel: 01189815147
Website: www.seeability.org

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 6 and 7 February 2018. The service was last inspected in September 2015 when it was rated as Good but had one breach of Regulation 17. At this inspection we found that the required improvement had not been made therefore this service is now rated overall as Requires improvement.

Fir Tree Lodge is a bungalow which has been adapted to provide accommodation for 10 young adults with a physical disability, learning disability, sensory impairment and/or autism spectrum disorder. There were 10 people living at the service at the time of our inspection. Each person had their own room and bathroom. Rooms have their own enclosed garden space in addition to a communal outdoor space. The bungalow is on the same site as other services that the provider manages.

Fir Tree Lodge is a 'care home'. 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.

There was a registered manager 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.

Medicines were not managed safely; there had been a number of medicines related incidents, which the provider had told us about. We found that the service had not always learned lessons from these incidents. Records relating to medicines were not securely stored.

Good practice in infection prevention and control had not been followed at all times.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Where people had their liberty restricted, the service had completed the related assessments and decisions had been taken but there was no record of what options had been considered and what had been discussed at best interest meetings.

People using bed rails did not have bed rail risk assessments, guidelines regarding the safe use of bed rails had not been sought so safety measures were not in place.

Person-centred care was not delivered consistently and the principles of this approach were not always followed by staff. People were moved in their wheelchairs without prior warning, staff did not always introduce themselves to people prior to intervention and people were not always told what was happening in their immediate environment.

Activity at the service was at times provided in large groups. People were not able to access the hydrotherapy pool at the time of the inspection. This meant the service did not always have a person-centred approach to activity provision.

There was a lack of governance at the service. Auditing systems were not robust enough to make sure the service was compliant with regulations and as a result, they had not identified the concerns we found during our inspection.

Staff were recruited safely, the necessary recruitment checks had been completed. Staff were supported with regular supervision and told us they felt supported. They had safeguarding training and knew signs of abuse and how to report concerns.

People had access to healthcare professionals. Health needs were recorded and guidance was available to inform staff what action to take in the event of a health related emergency.

Complaints were managed according to the provider policy. Records of complaints were kept following investigation.

We found four breaches of the Regulations. 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.

Medicines were not managed safely. Records relating to medicines were not stored safely.

Risks to people had not been identified in all areas, people who had bed rails in place had no risk assessments.

Staff did not demonstrate infection prevention and control good practice consistently during our inspection.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not always acted in accordance with the Mental Capacity Act 2005.

People were supported to eat and meal times were a social activity.

Staff were supported and trained in a range of areas specific to support people's individual needs.

The environment was purpose built to accommodate people who used wheelchairs.

Is the service caring?

Requires Improvement

The service was not always caring.

Basic principles of supporting people with sight impairment were not consistently observed. Staff did not always inform people they were near or that they were going to move the person.

The service did not consistently demonstrate person-centred approaches to people's care and support.

People's confidential information was not always kept secure.

People's rooms were personalised and people had been involved in decoration.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst people had activity plans in place the provision we observed did not reflect them. Activity was provided regularly in large groups.

Complaints were recorded, investigated and responded to within the provider's timescales.

Care plans were detailed and gave staff guidance about how to support people.

Whilst end of life care was not provided people had opportunity to make plans for the end of their lives.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of governance at the service. Quality monitoring was not driving improvement. There was not a positive culture at the service to make sure staff delivered person-centred care.

Improvement that had been required at our last inspection had not taken place. Checks to make sure tasks had been completed had not improved.

Community links were limited due to the service location and the lack of resource.

The service worked with other professionals where needed.

SeeAbility - Fir Tree Lodge Residential Home

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.

The inspection was prompted in part by notifications of incidents relating to medicines management. This inspection took place on 6 and 7 February 2018 and was unannounced. The inspection was completed by one inspector.

Before the inspection, we asked the provider to complete a Provider Information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We looked at the information that we hold about the service prior to our inspection. This included statutory notifications from the provider that they are required to send us by law about events that occur at the home such as deaths, accidents/incidents and safeguarding alerts.

We looked at four recruitment files, medicines administration records, care and support plans, activity records, the handover book, communication book, training records, supervision records and other records relating to the management of the service. We reviewed team meeting minutes for September, October, November and December 2017. We looked at staff rotas for a two week period. We spoke to five members of staff, the registered manager, the deputy manager, the regional area manager and the quality and compliance manager. We spoke with one relative and emailed a further five for their feedback.

People who live at the service were not able to give us their views verbally so we observed their experiences on both days of our inspection.

We contacted seven healthcare professionals whom the registered manager told us had been involved at

the service recently, we had one response.

Requires Improvement

Is the service safe?

Our findings

Medicines were not managed safely. Prior to our inspection, we received eight notifications from the service informing us of medicine related incidents. Learning from these incidents had not always happened. For example, we found one person had prescribed medicines stored in their cabinet that had not been written on their medicines administration record (MAR). We checked with the deputy manager what these medicines were, they told us they had been stopped by the person's GP. They removed them from the person's cabinet during our inspection. In November 2017 the service notified us of a medicines incident where a person had been given medicine incorrectly as it was in their cabinet, they had not been harmed. Following all of the eight medicines incidents the service told us they would put measures in place to prevent reoccurrence. We discussed this with the registered manager and regional area manager during our inspection as we were concerned lessons had not been learned.

People's MAR were stored in people's rooms. Medicines were stored in locked cabinets and the keys were stored in key safes located next to the cabinet. At our last inspection we made a recommendation that the service look at guidance on how they could store MAR safely as we found they were loose in people's files. At this inspection, we found they were still loose in people's files, which increased the risk of them being lost. We raised this with the deputy manager at the time of our inspection. They told us they had implemented new instruction to staff to make sure MAR were stored securely but staff did not always follow these instructions.

The provider's policy stated that the temperature of the room where medicines are stored must be checked daily and not rise above 25 degrees Celsius. The registered manager and deputy manager were not aware of this procedure therefore there were no records of temperature checks. Some medicines are not as effective if they are stored incorrectly.

Where MAR had handwritten entries we found these were not signed by a member of staff, the provider policy states that all handwritten entries must be signed by two members of staff. This is best practice to reduce the risks of transcribing errors.

Topical creams had been prescribed but were not being signed when administered on people's MAR. When we checked people's care plans, we found there was no guidance for staff to know where to administer creams and when. The provider has a topical creams administration form for staff to use but it had not been completed. This meant the service could not be sure people had been supported to apply creams that had been prescribed. Where staff were administering medicines that had a variable dose they were not recording how many tablets or sachets they had administered. For example, one person was prescribed Movical to treat constipation. The prescribing instruction was to administer one or two sachets each day. Whilst staff had signed to record they had administered a dose there was no indication of how many sachets had been administered. This meant accurate records were not kept to record people's medicines.

Staff received medicines training as part of their induction. However, staff told us it was six months before they would start administering medicines after their probation period had been completed. Some staff told

us this was too long a period, by the time they came to administer medicines they struggled to remember their training.

Good practice guidelines for infection prevention and control were not always demonstrated by staff. We observed that soiled waste was not always disposed of appropriately. The bin for soiled waste was stored in a cupboard in the laundry. On the second day of the inspection, we found there was no yellow bag in the bin and soiled pads in sealed bags were being stored on the floor. People's medicines cabinets were dirty and in some cases had grains of powder inside. Medicines pots and syringes that were used to administer liquid medicines were rinsed under a tap not washed in warm water and detergent, which is the provider's policy. This meant that people were at risk of cross contamination as pots and syringes had not been cleaned effectively.

Risks had not always been identified or assessed. One person had bed rails on their bed. There was no risk assessment in place or guidance for staff to inform them where the bed rails should be placed on their bed. People can become trapped in bed rails if they are not placed in the correct position. The Medicines and Healthcare products Regulatory Agency have published guidance on the safe use of bed rails, which the provider was not aware of. We asked the deputy manager to address this at the time of our inspection. People had not been assessed for risks of developing pressure ulcers. Everyone at the service had limited mobility; this is a risk factor for developing pressure ulcers. Whilst we saw the provider did have measures in place for some people such as specialist mattresses and cushions, re positioning plans and barrier creams there was no record of risk assessment for anyone. This meant the service could not be confident all risk factors had been considered and all safety measures that could prevent pressure ulcers were in place.

The above areas are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment.

Three people living at Fir Tree Lodge had a 1-1 member staff during daytime hours. The service then provided a further four members of staff to support the remaining seven people, all of whom required two members of staff to complete any personal care or moving and handling. At night, there were three waking night staff. Staff told us the service struggled with staffing levels at times. One member of staff told us the staffing ratio was "hit and miss". The registered manager told us that if they were short of staff they would use agency staff or bank staff to complement their permanent staff. One relative told us, 'There is a high turnover of staff, although this is handled well it would be nice if there was more continuity'. The service used a dependency tool, which calculated staff hours based on people's needs. The regional area manager told us that recruitment had been slow and they were looking at different methods of attracting staff to the service. We reviewed staff rotas and found the service did have a full complement on most days. We found there were sufficient staff to keep people safe but at times people could not enjoy individualised activities due to the current staffing arrangements.

Relatives told us that they believed that people were safe at Fir Tree Lodge. One relative told us, 'I am confident that [relative] is cared for in a safe way'. Policies and procedures for the safe recruitment and selection of staff were comprehensive. We looked at three staff personnel files and saw appropriate recruitment checks were undertaken before staff commenced employment. We saw checks in each file included two references, a full employment history including a full explanation of gaps where found, identification checks and a Disclosure and Barring (DBS) check. The DBS carry out a criminal record and barring check on people who have made an application to work with adults at risk. This helps employers to make safer recruiting decisions and helps prevent unsuitable staff from working with people.

Staff were aware of the types of abuse, the signs and indications of abuse and how to report any concerns.

They were confident that any concerns would be dealt with by the registered manager or a senior staff member. Staff were aware of support available to them outside of the organisation where they could also raise safeguarding concerns. All staff received safeguarding training, which was refreshed annually. The provider had set up a free and confidential phone line, which staff could use to raise any concerns. A poster advertised this at the service.

People had behaviour support plans, which guided staff on how to support people should they become distressed or require specific support to de-escalate anxieties. These were well written with clear strategies for staff to follow to ensure people's safety. People's individual behaviours were recorded with a range of strategies to follow listed in an order. For example, it had been identified one person may punch out at staff. We saw that the strategies to support this started with a 'firm no', then if that was not effective the staff were to 'try moving away for five minutes' or to 'try distraction techniques'. Staff had received training in positive behaviour support, which made sure they had guidance on supporting people's behaviour that may be challenging.

Where people had health conditions such as epilepsy they had risk assessments in place and seizure protocols so that staff knew what to do and when to seek medical assistance. People were supported to take positive risks such as driving their own electric wheelchair, going out to watch rugby matches and taking part in cookery sessions. Risk assessments were enabling so that people had as much freedom as possible.

We observed staff had access to personal protective equipment such as gloves which we observed they used appropriately. In addition, they were observed to wash their hands regularly. Staff prepared food in the kitchen area and had received basic food hygiene training. The service had been inspected by an environmental health officer from Hampshire County Council who had awarded the kitchen a "five" rating. This meant that the kitchen had very good hygiene standards.

Risk assessments were in place for the kitchen, fire prevention and use of equipment. These were all reviewed regularly and were up to date. The service used tracking hoists, which were attached to the ceiling to support people to move and transfer. These were serviced regularly and kept well maintained. The service employed a maintenance person who completed regular safety checks; on the first day of our inspection, we could see they were testing the emergency lighting. The fire alarms were tested regularly and fire equipment was serviced.

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. We found the service was not working within the principles of the MCA. Mental capacity assessments had not always been completed. We found that where people had restrictions in place the options considered as part of the best interests meeting were not recorded. The service could not always demonstrate that other health care professionals had been involved in decisions where needed. For example, we reviewed the care and support plan for one individual who had a high-sided bed. There was an assessment of capacity in place and a record of a best interest meeting with the service and the relatives of the individual. The service had not recorded within the best interest process that they had consulted any healthcare professional such as an occupational therapist (OT). We were concerned about the use of high-sided beds and discussed these with the registered manager. We have asked them to look into their use and review whether they are the least restrictive option in all cases.

People can only be deprived of their liberty so that they 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 are called the Deprivation of Liberty Safeguards (DoLS). The service had applied to the local authority for DoLS authorisations, five had been granted and five were still being processed.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent.

One relative told us, 'The staff are well trained'. Another told us, 'I have witnessed shadowing for new staff, all staff seem very able'. New members of staff completed the provider induction, which included face to face classroom learning, some e-learning and shadowing a more experienced member of staff. The registered manager told us that on average a new support worker would shadow a mentor for up to two weeks. This could be extended if the new member of staff needed further learning. All new workers who had not completed the care certificate were expected to do so. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of the job role. It covers 15 standards, which include communication, privacy and dignity, duty of care and safeguarding. New staff had a probation period of six months with a 12 week review to make sure their induction was on target. Records demonstrated these procedures had been followed.

Staff had supervision every month and records were kept on their personnel files. A range of topics were discussed which included people living at the service and their needs. Staff had access to a range of training. Training records were kept and a report could be produced to support the registered manager to identify gaps in skills. Staff could attend team meetings, which were held monthly. Minutes were recorded and available for people to sign as read if they could not attend the meeting. Staff told us they felt well supported by the management.

The service used technology to promote independence and provide stimulation for people. One person used a 'smart chair'. This was a wheelchair that followed a tracking strip laid from the person's room to the communal areas. Once the wheelchair was lined up on the strip, it manoeuvred itself with limited actions needed from the person in the wheelchair. This meant the person retained some level of independence when moving about the service. People had their own iPad so they could access the internet, store photos of their family or read books and stories on them. Some people had their own smart phones, this meant they could text message their family or use apps such as 'what's app' to communicate with relatives.

People had support to eat and drink using various methods. Some people had a percutaneous endoscopic gastrostomy (PEG) feeding tube. This was a tube, which has been passed into a person's stomach through the abdominal wall. People have PEG for a number of different reasons, but mainly it is because people are not able to eat or drink orally. Other people needed support from a member of staff to eat. The registered manager told us that menus were changed every six months. They told us their menus had been produced following consultation with the speech and language team (SALT), as people had complex nutritional needs.

Drinks and snacks were available between meals. People could choose a hot or cold drink and from a variety of snacks. Lunch was prepared by staff and there was ample food available. People had the support they needed to eat and staff aimed to make meal times a social activity. Meal times were not rushed and everyone was included in the activity. People who had a PEG were included in the activity. For one person we saw that the SALT team had supported the service to enable 'taste sessions'. They had trained one member of staff to be able to offer the person small amounts of a food purely for pleasure.

People had their needs assessed and the service sought advice and guidance from healthcare professionals if needed. There were hospital passports in place, which contained information for healthcare professionals about people's individual needs if they were admitted to hospital.

The premises had been purpose built for people with physical disability so rooms, corridors and doorways were wide enough to be able to easily steer a wheelchair through. Each room had its own bathroom and a door, which led to a private garden space. There was breakaway space which was a smaller room available for people to use if they wanted to move away from others, or to have some peace and quiet. This room was also used for music therapy and sensory activity. The lounge area was large and bright with plenty of natural light; this also had a dining area and a large kitchen. There were doors, which led to a garden space. People could only access the garden with support from staff. The service was located adjacent to a registered nursing home and resource centre also managed by the provider. Access to facilities in the local community was limited and transport was required to access amenities or visit places of interest further afield.

Requires Improvement

Is the service caring?

Our findings

The staff approach was not always consistent with the principles of person-centred care, it was at times task orientated. We observed that on numerous occasions staff did not inform people that they were around, they did not greet people, they did not introduce themselves and they did not explain to people what was happening in their vicinity. Most people living at the service have some form of visual impairment, it is good practice to let people know when you are approaching them and what is happening before it happens. One example is when the emergency lights were tested. At this time, there were five people in the main lounge with one member of staff. Nobody was informed that the main lights were going to be turned off. Whilst the room did not become dark, it was noticeable. The staff member in the kitchen area called out "lights are being tested guys" but this was not effective in making sure people were aware. The main lights were then switched back on without warning making the room very bright again.

We observed nine people in the lounge being read a story by a member of staff. A different member of staff then took over reading the story, then another member of staff came and took over so they were reading the story, then the first member of staff came back and took over reading the story again. There were no explanations from staff about what was happening, no introductions or greetings by any of the staff. As the people listening to the story had visual impairments we could see that this could be confusing for them as they were not informed by staff if the person reading the story was changing.

We observed on numerous occasions that people were moved in their wheelchairs without warning or explanation. Staff often walked up behind people and moved their chair, they were observed to move it to a different position, move it to a different area of the lounge or in some instances out of the room completely. Staff did not tell people they were there, they did not explain what was happening or where they were going or why. People did not look or become distressed by these actions but moving someone without warning could cause anxiety or confusion. We discussed our findings at the time of our inspection with the regional area manager. They told us that working with people who had a visual impairment was their "bread and butter", it was work they took pride in being able to do well. They would expect staff to work to good practice guidelines.

People's care plans were stored with MAR in their own rooms. On both days of our inspection we observed that everyone's MAR were put in a line in the dining area. We asked staff why this was, they told us it was so staff could check if medicines had been signed for on people's MAR. This practice does not make sure that people's personal information is kept confidential. Whilst there was usually a staff member in this area, if they were supporting a number of people they could become distracted.

Routines at the service were noticeable. Whilst routine can be beneficial for some people so they feel secure, less anxious and confused, noticeable routine, which involved everyone at the service, is not person-centred. During our inspection, we observed a number of times where care or activity was being delivered to everyone at the same time. For example, at around 11am everyone was moved to the dining table for their mid-morning drink. Once this had finished everyone was moved back to the lounge area. At 11.30am, people were taken out of the lounge area and brought back in succession. We asked the deputy manager what was

happening, they told us that everyone was being supported with personal care so they were comfortable for lunch. Then at lunch time everyone was moved to the dining table, after lunch was finished everyone was moved away from the dining table. This does not support people to maintain their independence and receive care that is specific to their needs at the time they need it.

People did not always receive personalised support that met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We observed in people's care plans that people had chosen if they preferred to receive personal care from a male or female carer. We asked staff if they knew what people's preferences were, they did. People were supported with their personal care in their own room where they may feel more comfortable. Doors were closed and staff told us they would also close curtains and make sure only staff who needed to be present were there. One relative told us, 'They [staff] always ensure their dignity is protected, knocking on doors before entering, and asking what they want to do'.

One relative told us that, "[person] loves it here, it is so relaxing." They thought their relative was well looked after and seemed happy. Another relative told us 'They [relative] are always treated with respect and kindness. Their privacy is always respected'. Another relative told us, 'We think the staff are caring and work to maintain privacy and dignity'. Visitors were welcomed at the service at any time. There were no restrictions on when people could have visitors. People were also supported to go to their families for visits. People were able to visit for the day or for longer stays. One person visited their parents every week and stayed for a number of nights. This meant that people were supported to maintain relationships that were important to them.

Some social interaction that we observed was kind and compassionate. All of the staff that we spoke to told us they really enjoyed working with the people who lived at Fir Tree Lodge. People were addressed by their preferred name and supported by staff who had taken time to get to know people. One member of staff told us they had time to read people's care plans during their induction so they could get to know the person. One relative told us, 'The staff are incredible going above and beyond to learn what sort of things [relative] enjoys and provide personal care. He is always clean and well dressed'.

People had been encouraged to decorate their own rooms. We observed every room was different and personalised. One person followed London Irish rugby club, their room had been decorated in the club's colours. Another person loved the colour pink, this was a key colour in every aspect of their room, curtains, bedding and decorations. People had their own belongings in the rooms, there were pictures and photos up on walls and in frames, personal items were evident in and around the room.

If people needed an advocate there was a leaflet available giving information on which organisation people could contact. The registered manager told us there was nobody using an advocacy service at the current time but they had in the past.

The registered manager told us that people were supported to do their own shopping online. Whilst the service had minibuses to access the shops some people preferred to use the internet and have things delivered. This enabled people to maintain independence in this area.

Requires Improvement

Is the service responsive?

Our findings

People had activity plans in their files, which recorded their activity preferences. We saw that people had preferences such as music therapy, hydrotherapy or crafts. We checked the activity records and found that on a number of days the activity provision was a group activity for everyone or for a large group. For example, on the 6 February 2018 we observed nine people watched a movie and eight people had relaxation in the afternoon, in the morning nine people had stories in the lounge and nine people had done some cookery. On the 5 February 2018 we observed that nine people had taken part in casino games in the afternoon, in the morning eight people had taken part in a 'travellers club' activity. On the 4 February 2018 in the afternoon, we saw that nine people had taken part in music and lights in the lounge, in the morning eight people had taken part in music in the lounge. On the 31 January 2018, we observed that nine people had taken part in crafts in the afternoon. On the 29 January in the afternoon, we observed that 10 people had listened to Bob Marley music. We struggled to find occasions where people were doing individual activity or activity that involved going out into the community. On occasion group activity may be beneficial for people, being with peers could give encouragement and support, however group activity should not be the main option for people. This is not person-centred provision.

There was a hydrotherapy pool on site but staff told us that the hydrotherapy was not happening at the current time. We checked with the assistant physiotherapist why this was, they told us there had been concerns about staff skills supporting this activity so it had ceased until staff were properly trained. We saw in people's records that hydrotherapy was part of their weekly plan; this meant that people were not able to engage in an activity that had been assessed as therapeutically beneficial.

Over the two days of inspection, we observed that two people went out in the mini bus on one occasion. This was to take one person home to their family, so another person went out for a ride in the bus. We observed one other person go for a walk. We discussed this with the registered manager who told us that not all staff had the training or necessary permission to drive the bus. As the service location was not near to local shops or other amenities this meant that people were isolated to the site. Due to staffing rotas there was not always enough staff to support people engaging in activity of their choosing.

One member of staff told us, "People are capable of doing so much more than they get credit for, staff need to do more activity with people." There was a lack of opportunity for people to follow individualised activity.

People did not always receive support to maintain their sense of self, their independence and be involved in their local community. This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Care plans were in place for people and had been reviewed in line with the provider guidance. There were detailed care plans for each person's health need such as epilepsy. Where people had a diagnosis of Autism spectrum disorder, this was documented with information for staff and details about how to support the person. People's routines were detailed so that staff had a step by step process to follow to support anxiety around certain activity. For example, one person had a detailed step by step guide for getting ready for bed.

The plan informed on the order that activity had to take place as the preferred routine stopped the person becoming distressed.

People's emotional and social needs were recorded and plans put in place to meet these needs. The plans were written positively making sure the focus was on what people could do, not on what they could not do. There were pictures used to give staff a clear indication of how things should be for people. For example, one person liked their cushions in bed in a very specific way; there were pictures in place of how each cushion should be placed. For a person who liked their wardrobe kept in an order; there were pictures to guide staff on how that order should be kept.

People had health plans, which were pictorial and written in a simple, clear format. The plans we reviewed were updated in January 2018. Nobody at the service was nearing the end of their life but the service had supported people to make decisions about what they wanted to happen at the end of their life. Some people had end of life care folders in their rooms, which informed staff what the person's wishes were.

The Accessible Information Standard is a framework put in place 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. We saw people's needs had been assessed and a form to document how people required their information was in their care plan. People's preferences ranged from face to face communication, audio preferences, interpreters and articles for the blind scheme.

The service had recruited four volunteers. They were involved in the service delivery and helped with a range of activity. One volunteer helped with administration at the service whilst one volunteer took a person to watch their rugby team. One volunteer had enjoyed their experience enough to apply for a permanent job at the service and become a support worker.

An external music therapist visited the service once a week to do a group music therapy activity and then later during the day they worked on a 1-1 basis with some people. We observed one of their 1-1 sessions. The person was smiling and relaxed throughout and engaged in the session. It was evident the person was enjoying their session.

There was a complaints procedure in place and the registered manager kept detailed records of complaints, their investigation and the outcome. The provider had an informal and formal procedure. One relative told us, 'If I needed to complain it is always possible to talk to the manager, I am confident that any worries would be dealt with quickly and efficiently'.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led. At our last inspection, we found a breach of Regulation 17 as the service did not keep accurate records for checking tasks had been completed on each shift. At this inspection, we found that this had not improved. We checked the records that shift leaders completed and found there were two weeks missing. We asked the service to locate these records. When they were found, we observed they appeared to have been filled in by the same person. We checked this with the deputy manager who following a brief investigation found that a member of staff had filled them all in following our request to see them. There were also gaps in the records where staff had not signed, this meant the registered manager did not have oversight of the tasks that had been completed.

We reviewed minutes from a number of team meetings. Not all meetings were attended by all the staff, so the service had a signing sheet for staff to sign that they had read meeting minutes. This was not effective as we found that very few staff had signed the form. This does not give us confidence that all staff were aware of the issues that were discussed in meetings.

We had been notified of eight medicines incidents over the past 12 months. There was no action plan in place to drive improvement at the service in this area. As part of the notifications sent, we were told that the staff involved would be re-trained in medicines, there was no evidence that this had happened. The service also told us they would raise medicines management in team meetings. We could not see this item on the agenda or in any meeting minutes. This is not an effective method of sharing information as attendance at meetings is low, and staff do not always read the minutes. The provider published an amendment to their medicines policy. We saw the new medicines policy was available with a sheet for staff to sign to say they had read it and understood it. Out of 30 members of staff only four staff had signed to say they had read the policy. The policy had been made available on the 4 December 2017. This is a concern due to the number of medicines incidents at the service.

Care plans had signing sheets in place for staff to sign to state they had read the person's care plan. We found a number of care plans where only 10 out of 30 staff had signed to say they had read the care plan. Whilst staff may know the person's needs and be able to give the support required gaps in the records at the service is a concern. This concern had been identified in the regional area managers quality monitoring visit in August 2017 but was still 'ongoing'.

The senior team completed weekly checks and monitoring. This was documented on a form and an action plan produced. We reviewed these forms and found a number of concerns. On one form, we observed that evening medicines had not been recorded as given on two consecutive days. There were no actions recorded. It was recorded that one person had been given sugary food on two consecutive days when they were meant to be on a reduced sugar diet, again there were no actions recorded. We saw these same issues were recorded on the monitoring form for December 2017 and again in January 2018. There had been no action taken. Whilst the service had identified areas of improvement there was no record of what action needed to be taken in order to make the required improvement. Systems and processes in place to assess, monitor and improve the quality and safety of the service must be robust and effective.

The above areas are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Feedback from people and or their relatives had not been formally sought since 2016. The provider told us that they were in the process of seeking feedback at the time of our inspection, surveys had been posted out and had started to be returned. The provider showed us some samples of what had been returned so far.

Staff told us the registered manager and deputy manager were mainly office based. Their presence was not always visible to people or staff. The service had recently tried to recruit a physiotherapist to replace a member of staff who had left but this had not been successful. This meant this role was no longer available to the service. There was an assistant physiotherapist employed but the service lacked visible leadership day to day, which the physiotherapist role helped to provide. The registered manager told us that they had recognised this point and had already put a plan in place to make themselves more accessible to people and staff.

The registered manager told us that there was a "no blame culture" at the service. This meant that staff could report mistakes and concerns without fear of retribution. Some staff told us that it did not always feel like a 'no blame culture'. One member of staff told us they had raised an issue about a member of staff's practice during their supervision, they were then expected to sit in a meeting with the registered manager and the other member of staff and tell them what their concerns were. This approach felt intimidating to the member of staff raising the concern; it had discouraged them from raising any further concern directly to the registered manager. Another member of staff told us the same approach had been taken when they had raised an issue. They told us they did not mind the "three way meeting" and felt comfortable telling colleagues what issues they had with them.

Morale amongst some of the staff team was low. Some staff told us that they were leaving because of the morale and management style. There had been a high turnover of staff at the service in the past year. The regional area manager recognised this and told us they had planned to do some 'well-being' work with the team.

Community links were limited. People did not regularly have the opportunity to access their local community. The service had used volunteers to try to improve experiences for people but this was an area that required improvement.

The provider had a new set of values as part of their new five year strategy. The values were on posters available at the service and were part of the provider staff induction. The registered manager told us their vision for the service was to move forward with personalisation. They planned to involve people more consistently in a person-centred review. People had a standard review annually as per the provider policy. The registered manager wanted to enhance this to increase the frequency and find more innovative ways of involving people.

The registered manager was supported by a regional head of operations who visited the service at least monthly. They routinely completed a formal quality monitoring audit three times a year. They also attended 'managers meetings' where managers from all of the provider's services could meet and exchange ideas and best practice. One relative told us, 'We would not have any hesitation in approaching [the registered manager] and we have every confidence in their leadership'. Another relative told us, 'Senior staff are always visible and take ownership'. The registered manager was aware of their registration responsibilities. We saw the rating from the previous inspection was displayed and notifications were submitted to us in good time.

Any concerns were always raised with the local safeguarding authority and the service worked with a number of different funding authorities. Following a recent safeguarding concern, the service had worked in partnership with all their funding authorities to make sure everyone at the service had a review. We contacted the local authority following our inspection to check on the status of this concern to be informed it had been closed.

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 The delivery of the care was not personalised. Routines were observed to be based on the group of people living at the service not the individual.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had not demonstrated that the least restrictive option was in place at all times. Best interest meetings did not evidence options considered and what the discussion around decisions had been.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. The provider's policy for medicines management was not always being followed. Risks had not always been identified and assessed with the necessary safety measures put in place. Infection prevention and control best practice had not always been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective in

assessing, monitoring and improving the quality and safety of the service.