Independent Options (North West)

Hall Field Guest House

Inspection report

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Date of inspection visit:
21 September 2016

Date of publication:
25 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 September 2016 and was unannounced. The service was previously inspected in October 2013 and at the time was meeting all regulations assessed.

Hallfield guest house is a beautiful Victorian property close to the centre of Stockport, with six en-suite guest rooms, one of which is fully accessible for those who have physical disabilities. The guest house also features a dining room and a large and comfortable living room where guests are able to watch TV, play games, and take part in activities. Hallfield Guest House is based in Offerton in Stockport and is registered to provide accommodation for up to six people who require nursing or personal care. At the time of our inspection there were four people receiving a respite service at the home. Respite care is planned or emergency temporary care provided to caregivers of a child or adult with special needs.

There was a manager in post and a new manager had been employed with an application in progress with the Care Quality Commission (CQC) to be the registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's care plans included information about their care and support including associated risk assessments, however, where there was evidence of additional risks for example the use of bed rails, and risks to evacuate people in the case of an emergency, risk assessments had not always been completed. We saw actions as a result of identified risks for legionella had been recorded but these had not always been completed.

Care records were not always detailed and person centred information had not been completed to provide care workers and others involved with the persons care with information on the persons background. Where care plans had actions documented to provide person centred care with people those actions had not always been completed. Care and support did not always reflect their personal preferences.

Care workers had received training in the administration and management of medicines and policies and procedures were in place to provide them with further guidance. Despite this, we found that information available to administer people's individual medicines safely was not always completed accurately and was not always reflective of people's current needs.

Checks were completed that included quality assurance audits but despite these measures in place we found that they were not always effective in identifying the concerns we highlighted for risk, medication and people's records.

We found other checks on the home and the environment had been completed by the registered provider and these checks were up to date. They included fire risk assessments and electrical equipment checks.

A process was in place to record and manage accidents and incidents and this helped to prevent re-occurrence and helped to keep people safe from avoidable harm.

The registered provider had in place an electronic rota that ensured sufficient care workers were on duty to keep people safe and meet with their individual needs. The registered provider had completed pre-employment checks to help ensure only those care workers assessed as being suitable to work with vulnerable people had been recruited.

People told us they felt safe. Care workers understood how to recognise and report signs of abuse and harm to people and up to date guidance was available.

People we spoke with told us they felt supported and that care workers had appropriate skills to meet their needs. Care workers received training that provided them with the skills and knowledge to undertake their role and enabled them to meet people's individual care and support needs. They were supported in their role by management and they received regular documented supervisions.

Care workers had received training and had an understanding of the requirements of The Mental Capacity Act 2005. They understood that when people 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 looked at people's care plans and saw people or their representatives were involved in their care planning and where people had capacity, consent had been sought that confirmed they agreed with the care and support provided.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. Where people had religious dietary requirements, these were documented and catered for.

People were encouraged to be independent as possible and were encouraged to assist with activities including meal times and during personal care by care workers. We saw care workers understood the importance of and promoted people's privacy and dignity and they told us how they ensured people's confidentiality was maintained.

The service often provided younger people with their first experience of independent living for short periods of time (Respite) away from their families. We saw care plans included information on people's aspirations and goals and a weekly routine was documented and appropriate support plans were in place to meet the outcomes.

People were supported to follow their interests and take part in social activities and people were protected from social isolation with a variety of activities and support on offer.

People were supported to raise concerns and complaints. We saw documented complaints included details of the complaint, actions taken and details of the investigation, calls and contacts made and where appropriate a multi-agency response meeting.

The registered provider held coffee mornings for people and their families and undertook quality assurance surveys that helped shape and develop the service that people received. Care workers told us they thought these measures were important and provided examples of where changes had been implemented because of the feedback received.

There was positive feedback about the management and the manager knew about their registration requirements with the CQC and was able to discuss notifications they had submitted as part of their conditions of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Despite systems in place to manage risks, people were not always safe because documents had not always been completed reviewed or updated.

People had received training in medicines management however; systems and processes in place to ensure medicines were administered and managed, required improvement.

Sufficient care workers had been employed and pre-employment checks had been completed that helped ensure people were only supported by care workers that were considered suitable and safe to work with them.

Policies and procedures were in place to guide care workers in how to safeguard people from abuse and they received training about this.

Is the service effective?

Good

The service was effective.

Care workers understood the principles of the Mental Capacity Act 2005 (MCA) and took appropriate action to ensure people's rights were upheld.

Care workers received the training they needed to support people effectively.

People were supported to have a healthy and nutritious diet and to receive appropriate healthcare when required.

Is the service caring?

Good

The service was caring.

People who used the service told us they were treated in a kind and caring manner and were encouraged to be independent. Their privacy and dignity was respected.

People told us they were happy with their care and had developed positive relationships with their care workers.

People were involved in decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always detailed and person centred information had not been completed. Care and support did not always reflect people's personal preferences.

People had the opportunity to participate in a wide range of activities.

People were supported to raise concerns and complaints and information was available in a variety of formats.

Is the service well-led?

Requires Improvement

The service was not always well led

The registered provider's quality assurance procedures were not always effective and did not identify the issues we found during the inspection.

Car workers told us that management were supportive and that they would not wait to raise any concerns.

There was a warm friendly atmosphere and care workers spoke of a positive culture where the manager was working hard to improve the service for people.

Hall Field Guest House

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 was carried out on the 21 September 2016 and was unannounced. The inspection team consisted of one Adult Social Care (ACS) inspector. Before the inspection, the provider completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home.

On the day of the inspection, we spoke with two people who received a service in the home. We also spoke with three care workers, the manager, a newly appointed manager and a registered manager from another service.

As part of the inspection, we reviewed the care records for three people including their medicines records and risk assessments. We also looked at three staff files and other records used in running a care home that included quality assurance systems, policies and procedures and health and safety records. We observed the care and support being provided to people and looked at the management and administration of medication process. We looked around the home and in people's rooms with their permission.

Requires Improvement

Is the service safe?

Our findings

We saw people's care plans included information about their care and support including associated risk assessments. We found these identified the risk, any triggers, agreed actions to mitigate the risks and a desired outcome to help keep the person safe. This information provided guidance that helped people to receive care and support in a safe way and live safely in their environment. The registered provider told us on the PIR, 'We will be reviewing and developing person centred risk assessments because we want to work with service users in a more person centred way to protect their dignity and rights and to support them to manage risk behaviour.'

We saw that where bed rails were fitted in people's rooms associated risk assessments management and guidance for their use had not been completed. We spoke with the manager about this and they told us, "Bed rails are fitted in case they are needed but at the moment we don't have people who need them [to keep them safe at night]." This meant that bed rail safety checks had not been completed for their use, and guidance to use bed rails in a safe way was not available for care workers to use to help keep people safe from harm.

The manager showed us a file that contained a risk assessment for prevention and checks, on hot and cold water systems for the control of Legionellosis which is a serious type of pneumonia (lung infection) caused by bacteria called Legionella. The risk assessment was completed by a contractor in July 2016, expired in July 2017 and included actions to mitigate the associated risks. Actions documented included three monthly showerhead cleaning and recorded hot water temperature checks. These actions had not been completed and documented which meant the registered provider failed to address actions highlighted to prevent the spread of water borne infections. We spoke with the manager about this and they advised us that checks would be implemented and recorded.

The above concerns meant that appropriate risk assessments were not always in place and where actions had been identified to mitigate risks these had not always been implemented which meant people were not always kept safe from avoidable harm.

We found that information for care workers to assist people to evacuate the building safely in the event of an emergency had not been completed. The manager told us this was being reviewed. After the inspection, they provided us with a template for a personal emergency evacuation plan (PEEP) that will be implemented for each person. PEEPs are documents, which advise of the support people need to leave the home in the event of an evacuation-taking place.

Despite some policies and procedures in place to manage and mitigate the associated risks of administering and managing medicines, information for care workers was not always up to date or reflective of a person's current prescribed medication. This meant peoples medicines were not always administered safely. The registered provider told us on the PIR, 'Medication administration training, administration forms and policy ensures that medication is managed safely.' We found policies and procedures were in place and care workers had received comprehensive training and competency observations in the management and

administration of people's medicines. Guidance had been completed in line with information from the Care Quality Commission (CQC) and 'medicines management guidance for care homes' from a local authority. A record of medication errors was provided that showed corrective action taken where errors of medicines management and administration had been identified. Despite this we found that information recorded in the medication administration records (MAR) did not always contain up to date information on people's medicines and were not always reflective of the information documented in peoples 'personal information forms.' For example, we saw that one person received Febuxostat, a medicine for gout. The information recorded 20mg of the medicine was to be administered on personal information forms but the MAR recorded 80mg. Another person was prescribed 5mg Prednisolone, a steroid medication. This had been recorded on the MAR but the medicine was not included in the personal information file and a prescribed Sirdupla, a medicine for asthma was recorded on the MAR but not on the personal information record. We discussed our concerns with the manager who told us, "The information should be updated as it changes to reflect the person's medicines." One person had been prescribed the use of oxygen. This was documented in their care plan however, the oxygen hazard warning notice was not displayed in the home.

The above concerns are a breach of Regulation 12 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. At the time of our inspection, the manager told us there were no people in receipt of controlled drugs in the home. However, we were concerned that some people using the home for respite services may bring prescribed controlled drugs with them and there was no facility to store controlled drugs in line with safe storage guidance by the National Institute for Health and Care Excellence (NICE) should this be required. We advised the manager to look at further guidance regarding this. A fridge was available for the storage of medicines that were required refrigeration at a constant temperature.

The fire file we looked at contained a fire policy and risk assessment to provide guidance for employees in the event of a fire and a signature sheet had been signed to confirm employees had signed and understood this guidance. A map of fire exits and weekly fire checks had been completed and a fire engineers report had been completed. These measures helped to mitigate and manage associated risks in the event of a fire.

Other checks to help keep people safe in the home included annual gas safety record, portable and static electrical appliance testing, Lifting Operations and Lifting Equipment Regulations (LOLER) checks and mobile hoist checks and these were up to date.

We looked at how accidents and incidents were recorded and their outcomes managed. Information included the person involved, the location of the accident/incident a description of the event and further evaluation by the manager. The manager's evaluation documented a review of the event, how it could have been prevented and steps to prevent re-occurrence. The manager completed any changes in policy because of the evaluation and any implications for changes to further practice were actioned. This meant that the registered provider had systems and processes in place to manage and learn from accidents and incidents and that the process helped to mitigate any future re-occurrence, which helped to keep people safe from harm.

The registered provider had in place an electronic rota that ensured sufficient care workers were on duty to keep people safe and meet with their individual needs. The rota included information to document when care workers were on training or were unavailable. Substitute employees had been added to provide cover. Staffing was adjusted dependant on the number of people staying at the home and took into account any

activities that required one to one support between a care worker and a person undertaking the activity. Care workers told us staffing was regularly discussed at team meetings and minutes of the meetings we looked at confirmed this was the case. The manager told us, "Staffing is based on people's individual needs, we try not to rely on agency staff and we have three care workers who are sessional; they pick up any shortfalls where we have reduced availability." A care worker told us, "There are enough of us [care workers] to provide care and support with people; we could always do with a few more to help with activities and at weekends but its ok," they continued, "We are employed for twenty five hours a week and there is always opportunity to pick up overtime if we choose to."

We looked at the recruitment records for three care workers. Information available did not contain pre-employment checks as the manager told us this information was held centrally. We asked the manager to provide us with details of the checks they had undertaken for all eleven care workers after our inspection. We were provided with employee start dates and information to confirm that checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. It was evident that four DBS checks had been received after the employee start date. The registered provider told us at least one of those was a new DBS check to replace the one in place by the previous employer and they told us care workers were never left to work alone with people until all checks had been completed. We found that other information provided included details of additional checks made by the registered provider and included pre-employment references, application forms and right to work in the UK documents and these had been completed prior to the employee commencing work. These checks helped to ensure only care workers deemed suitable to work with vulnerable people had been employed.

People we spoke with told us they felt safe. One person said, "I don't have any concerns about my safety and the staff are wonderful." Care workers we spoke with understood how to recognise signs of abuse and discussed appropriate action they would take if they had concerns. A care worker said, "We have a duty to keep people safe from harm and abuse and I wouldn't hesitate in whistleblowing any concerns to senior management, local authority or the CQC [Care Quality Commission]."

The registered provider showed us an up to date safeguarding policy in line with the local authority policy that provided care workers with guidance on 'working together to prevent and deal with abuse.' The manager told us they used a threshold tool to evaluate concerns of abuse and that they investigated levels one and two internally, levels three and above were referred to the local authority for further investigation. The registered provider told us on the PIR, 'All staff attend Safeguarding Adults Alerter training, and where appropriate Child Protection Training; this ensures they are able to respond appropriately to any safeguarding incidents.' Training records confirmed that care workers had undertaken appropriate safeguarding training that included refresher eLearning to ensure their knowledge was up to date. At the time of our inspection, there were no concerns under investigation but the manager had previously submitted safeguarding concerns to the local authority and the CQC to ensure these were appropriately investigated. This meant the registered provider had measures in place to learn from events which helped to prevent re-occurrence.
The registered provider had a policy and guidelines for the control of infections in the home and this was up to date. Information included a protocol for the management of MHRA, Diarrhoea, Antibiotics, Clostridium Difficile and information on blood Bourne viruses and guidance on immunisation. All care workers completed infection control training and a weekly cleaning schedule was in place which was signed and included completed actions. These measures helped to ensure people were protected from the risk of infection and infectious diseases.

Good

Is the service effective?

Our findings

People who we spoke with at the home told us that care workers knew how to support them and had an understanding of their needs. One person told us, "I really like the care workers here, [care worker] is really nice and knows me; they are helpful and I look forward to staying here."

We looked at how care workers were supported with training, professional development, appraisals and support to carry out their roles. We saw that care workers had a supervision programme which was centred on the employee. Information included reviews of any actions from previous supervisions, revised targets, team and organisational discussions, service user reviews, discussions on the person's role, learning, training and further development. We saw agreed actions had been completed between the manager and the care worker and that the care worker had signed their agreement to the content. Care workers we spoke with told us they received regular documented supervisions and annual appraisals. One care worker said, "I do feel well supported and my manager is very approachable and responsive to any concerns." This meant that care workers were supported in their role and opportunities to improve their practice and develop were provided.

The registered provider told us on the PIR, 'Staff undertake a comprehensive programme of training, starting with induction including the Care Certificate.' The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. We saw from training records in care workers files that care workers were completing this training. A care worker told us, "I completed an initial two week induction that included an introduction to the home and the environment; this was followed by shadowing experienced care workers." They continued, "I had to complete an induction book and other training and the manager signed this off after I completed the shadowing to ensure I had completed and understood everything." They said, "The process was very thorough and gave me a lot of confidence to start my role." This meant the registered provider had systems in place to ensure care workers understood the requirements of their role, the policies and procedures in place and the needs of people who received a service.

The registered provider told us on the PIR, 'Staff are trained and supported to provide person centred care and support from induction." Care workers told us they felt the service supported them to ensure they had the right skills to undertake their work. Training was managed electronically ensuring care workers received appropriate training at the right time. Care workers we spoke with told us and we saw from employment records they had completed mandatory training. This included safeguarding, moving and handling, food safety and fire safety.

A care worker told us, "The training here is really good and well managed, we are just told what we need to attend and when," they continued, "It's a mix of classroom and on-line learning." Another care worker said, "Training is adapted to meet people's individual needs, which means we can acquire a range of skills so we can meet people's individual care and support needs." We saw additional training included epilepsy, autism and understanding behaviour and that this meant care workers had the required skills and knowledge to meet people's individual needs.

Care workers had received training and had an understanding of the requirements of The Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where the registered provider had concerns around people's capacity or where they were deprived of their liberty, applications had been submitted to the local authority for a deprivation of liberty safeguard (DoLS) authorisation. A DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. A registered provider must notify the CQC about any applications they make to deprive a person of their liberty under the Mental Capacity Act 2005 and about the outcome of those applications. A higher than expected number of DoLS applications could mean a location is not using the safeguards appropriately, potentially depriving people of their liberty unlawfully. On the PIR, the registered provider had notified the CQC of eighteen applications for a DoLS in 2015 and said, 'Staff understand that people have the right to make their own choices and where it is necessary to act in someone's best interest.'

We looked at people's care plans and saw people or their representatives were involved in their care planning and where people had capacity, consent had been sought to confirm they agreed with the care and support provided. One person at the home told us, "[Care worker] speaks with me and my mum about my care plan."

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. The registered provider told us on the PIR, 'As part of a guests individual support plan we identify nutritional needs, religious/cultural requirements around food and peoples likes and dislikes; we support a range of guests who have specific dietary needs for example gluten free diet and halal.' We saw this information documented in people's care plans. A care worker told us, "If we have any concerns about people's diets we record it and we would call a doctor if required who can refer the person to a dietician."

People were supported and their health care needs were monitored. The registered provider told us on the PIR, 'As a Short Breaks Service we are not usually asked to accompany guests to medical appointments, however should a guest need medical attention whilst on a short break we would ensure we support the guest to receive the relevant medical support.' Care workers told us any changes in people's health or well-being prompted a referral to their GP or other health care professionals. We saw information about other health professionals involvement in people's care had been documented in care plans. These included contact details for GP's, dentists and social workers. One person we spoke with confirmed that they were able to access their GP when needed. They said, "I can see a doctor when I need to." A care worker told us," The service is mainly provided for respite so people don't stay with us long but whilst they are here we make sure they are well cared for and supported." The manager said, "Where people have complex needs such as epilepsy we complete monitoring charts for them and this information is fed back to carers at the end of their stay and professionals on request or following a particular concern."

Good

Is the service caring?

Our findings

We asked care workers how they knew people in the home. They told us "We get to know people by spending time with them and also by speaking with their families and other people involved in their care and support," and, "Some people have complex needs so we can look at the care plans, they are personalised and have a section called 'All About Me' but sometimes this needs updating." They told us, "There are a maximum of six people in the home at any time and one or two will usually undertake days out and other activities so we have plenty of time to get to know people on a one to one basis."

The atmosphere in the home was calm and friendly with people in different areas of the home. We observed care workers chatting to people in communal areas and people responding positively. For example, one person arrived at the home for a short stay and a care worker sat and discussed what they had being doing and showed a genuine interest in the person's activities.

During our inspection, we observed care workers supporting people with daily tasks and encouraging people to maintain their independence. A care worker told us, "We are quite good at involving people in their care and support, we make sure people can do as much for themselves as possible, for example at meal times we encourage people to help prepare as much of the meal as they can, that might be just buttering toast but it gets them involved."

We saw care workers promoted people's privacy and dignity. Care workers knocked on people's doors and waited to be asked in before entering. A care worker told us, "I treat people how I would wish to be treated in my own home. I discuss any task with the person to ensure they are clear of what we are doing and why and I make sure they are in agreement before proceeding."

Any personal care and support was conducted behind closed doors. Care workers told us when supporting people with any personal care they would always ensure this was done with the person's door and curtains closed as appropriate for the task and would always ensure that people were covered when supporting with bathing. A care worker said, "I always explain what is happening and encourage the person to do as much as they can to assist me."

Care workers understood the need to maintain people's confidentiality. Care workers told us, "People do confide in us like a family member, it is important that we don't share or discuss anything with anybody who doesn't need to know or who are not involved with the persons care, unless of course they are at risk from harm" and, "If someone wants to discuss something privately, I always suggest we go to their room or find a quiet corner away from other people, it's important that people are able to speak with us confidentially."

Discussion with care workers revealed that where there were people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation that their needs were met. We were told that some people had religious needs and beliefs and we saw these were adequately documented and provided for within the service and by people's own family and spiritual

circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Requires Improvement

Is the service responsive?

Our findings

The manager told us, "People come into the home for a respite service [short break]; we speak with their families and representatives before we accept their application to provide them with care and support to ensure that the service will meet with their needs." We saw individual assessments had been completed and documented and that this information formed the basis of the persons support plan.

We looked at three care plans for people. We saw these had a section that provided opportunity for the registered provider to document information about the person called, 'all about me'. However, we found this had either not been completed or contained limited information. For example we saw a further section 'What people say about me' documented that the person 'Can help sometimes' but no further narrative had been included. The registered provider told us on the PIR, 'We intend to ensure that all guests have a completed and up to date One Page Profile and All about Me Document.' There was no information documented that provided a background to the person, their lives or their personal history.

We found other information in care plans to support care workers to provide personalised care had not always been updated or completed. For example, a care plan contained information to provide care and support to a person who was deaf. The support plan included actions to train care workers in sign language and to use visual aids to help with communication and to respond to the person's needs. We saw from training records that this training had not been implemented. The registered provider told us after the inspection 'A file containing PECS sign cards and tools was in place, at the date of inspection, to facilitate basic communication and all staff were in receipt of communication training.' However, during the inspection a care worker told us, "I would like some training in sign language but we usually communicate with [person] by showing them things such as tins of food or fruit and gesturing which one they would prefer." We spoke with the manager about this during the inspection and they told us they were looking to implement some training but not necessarily sign language. They told us they needed to further review the support for this person to help care workers with communication to meet the person's needs.

This meant at the time of our inspection that the registered provider did not always ensure that people received personalised care that was responsive to their needs and information available to provide care and support by care workers was not always reflective of people's preferences. This was a breach of Regulation 9 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

The manager told us that the respite service often provided younger people with their first experience of independent living away from their families. We saw care plans included information on people's aspirations and goals and a weekly routine was documented. A care plan contained information to support a person to attend a day centre. This included the time of the attendance, transport requirements, money required, food and any clothing preferences. People were supported to undertake activities and were assessed as to the amount of support they would require. Activities available included swimming, bike riding, cinema and shopping. Assessments confirmed if the person could complete the activity independently or the amount and type of support required and appropriate support plans were in place to meet the outcomes.

We saw people were supported to follow their interests and take part in social activities and people were protected from social isolation. We observed people in the home watching television, colouring in books and pictures and care workers were on hand to assist people if they required. A care worker told us, "We encourage people to be active and involved as much or as little as they wish."

The registered provider had an up to date complaints, compliments and suggestions policy and we saw the service user guide included information for people on how to complain. This information was in written and pictorial format that helped people to understand the complaints process. We asked care workers if people knew how to complain. They told us, "We get to know people and their moods, we know if they are happy or sad by their body language and facial expressions and we ask them if they are ok; it's about knowing and understanding the person." The manager told us, "We discuss any concerns people raise with families and other people involved in people's care and we take any complaints seriously and will always investigate." We saw documented complaints included details of the complaint, actions taken and details of the investigation, calls and contacts made and where appropriate a multi-agency response meeting.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in place who was in the process of applying to be registered with the Care Quality Commission. The manager was on duty and supported us during the inspection.

The registered provider told us on the PIR, 'Managers and senior managers undertake quality audits.' The registered manager told us and we saw they undertook a range of monthly internal audits. These included checks on service user files, medication and staff supervisions. We were provided with a copy of an audit feedback for medication and progress control sheet that confirmed where audits had been completed. However, despite the measures in place we found these were not always effective in their purpose. Our findings included areas of identified risks to people that had not been updated and measures in place to reduce or minimise risks had not always been implemented or completed. We found that despite systems in place to ensure medication was managed and administered safely, information, recording and equipment for storage of medicines was not effective and policies, procedures and best practice had not been implemented. Audits of peoples care records had not ensured that care plans contained person centred information about the persons history and that these and were not always reflective of peoples individual needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service were encouraged to have their say, we saw service user meetings were held where people were given the opportunity to discuss any issues and raise any concerns. The registered provider told us on the PIR, 'Regular coffee mornings are held where families can attend and share any concerns, suggestions or complaints.' We saw copies of minutes from the meeting and it was clear that people and their families provided feedback and were involved in shaping the care and support they received and that people's concerns were looked into and actions implemented as a result.

We saw the registered provider had undertaken an annual survey with people and their families in the home. The results of the service showed that out of 47 people, 44 people agreed that they had been involved in the planning of the persons care and support and out of eight people who needed to make a complaint all agreed they were satisfied with the outcome. A similar survey had been completed by service users and this was compared across other services provided by the registered provider. We asked care workers if quality assurance helped to drive improvement and they told us "It can do, we had a problem with televisions and for people using the computer and this has been addressed by feedback we received; the TV's have been fixed and we have a timer for people when they use the PC." This meant the registered provider had taken steps to make sure that feedback was collated from service users and their families and that they were involved in making decisions that helped to shape and improve the service they received.

There was a clear management structure in place and staff had an understanding of their roles and responsibilities. The registered provider told us on the PIR, 'The CEO is responsible for leading the organisation, setting the tone of our open and honest culture.' The manager told us, "We have had significant changes at management level but with the recruitment and application of a registered manager we are hoping for some stability." Care workers we spoke with told us that they felt the manager was

approachable and worked hard to improve the standards of care at the home. A care worker told us, "We have a good team and management is really supportive and responsive to any concerns."

The manager knew about their registration requirements with the CQC and was able to discuss notifications they had submitted. This meant they were meeting the conditions of their registration.

Care workers told us they were kept up to date with changes within the organisation and that people's needs were discussed and documented daily. The manager told us information about the organisation and the home was shared with care workers at monthly staff meetings. The manager provided us with a copy of minutes from the last meeting held in August. Discussions documented in the minutes included, rotas, service users, assessments, health and safety, infection control and quality assurance. Care workers told us, "We have regular supervisions every six to eight weeks and we are informed about any changes to policies and procedures," "We have to sign to indicate we have understood any changes so it's important we read them [the policies]." "Staff meetings are monthly, we discuss health and safety issues, organisational changes, any issues with service delivery; they are informative and keep us all up to date."

The manager discussed with us that the organisation is a charity and that it had a three year strategy for improving the services it provides. This was confirmed on the PIR which stated, 'We have a 3yr strategy for the development and improvement of the charity overseen by Board and implemented by the senior management team (SMT), all of who are experienced and well qualified in their field. The Strategy compliments our Person Centred Strategy, which is based on Progress for Providers; trustees are recruited systematically to ensure we have fit and proper trustees. Our ethos is about empowerment, independence and inclusion. In the strategy service managers have their own objectives regularly reported on to the Chief Executive Officer (CEO).' This meant the registered provider had plans in place that included analysis and reviews of the service and that these were inclusive of everybody in the organisation and this included the CEO and SMT who shared and drove the responsibilities for improvement along with the board.

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 Care and support documented was not personalised specifically to the person and information available to provide care and support by care workers was not always reflective of people's preferences. Regulation 9 (1) (a) (b) (c) and (3) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate risk assessments were not always in place and where actions had been identified to mitigate risks these had not always been implemented which meant people were not always kept safe from harm. Information for people's medicines was not always up to date and medication was not always managed and administered safely. Regulation 12 (1) and (2) (a) (b) (f) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place were not always adequate to effectively assess, monitor and improve the quality and safety of the service provided.

Regulation 17 (1) and (2) (a) (b) (c)