Coghlan Lodges Limited

Coghlan Lodges Limited

Inspection report

335b High Street
Slough
Berkshire
SL1 1TX

Tel: 01753580745
Website: www.coghlanlodges.co.uk

Date of inspection visit:
02 November 2016
03 November 2016

Date of publication:
12 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an announced inspection of Coghlan Lodges on 2 and 3 November 2016.

Coghlan Lodges provides personal care and support to people living in ten supported living schemes. At the last inspection on 5 August 2015, we asked the provider to take action to make improvements in their management of medication, increasing people's independence, notifying the CQC of important events and to improve their quality auditing arrangements. There were two breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. At this inspection we found some improvements had been made but further actions were needed to ensure the provider met the regulations.

At the time of the inspection nine of the schemes were occupied and 47 people were in receipt of a service.

There had been no registered manager in post for a period of over 12 months. We were informed there had been a delay in obtaining the necessary information to enable the person to register with the Care Quality Commission (CQC). At the time of inspection an application had been submitted, however this was rejected due to supporting evidence being out of date. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's medication was not managed safely. There were a number of recording errors on people's MAR charts, changes to specific medicines were not recorded and some staff had not followed guidance to keep people safe from risks when they missed their medicines. The provider was also failing to follow national pharmaceutical guidelines.

People's medicines were stored safely and in most cases people received their medicines when required.

People and their families told us they felt people were safe. Staff understood their responsibilities in relation to safeguarding adults. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People benefitted from caring relationships with the staff. We saw positive interactions where staff respected people's privacy and promoted their dignity. Relatives told us they were involved in people's care and people's independence was actively promoted. However, people who used the service were not always involved in their care reviews.

There were sufficient staff to meet people's needs. Staff rotas confirmed planned staffing levels were maintained. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff understood the Mental Capacity Act 2005 (MCA) but the provider had not applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The operations manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected. However, MCA assessments were not in place for people. Where people lacked capacity to make decisions the registered manager was not acting within the principles of the Mental Capacity Act (2005).

People had enough to eat and drink. People could choose what to eat and drink and their preferences were respected. Where people had specific nutritional needs, staff were aware of, and ensured these needs were met.

Relatives and professionals told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided. Learning needs were identified but actions were not always taken to make improvements to promote people's safety and quality of life. Systems were not always in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the manager. Staff supervision and other meetings were scheduled as were annual appraisals. Staff told us the registered manager and area manager were approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the registered manager and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not safely managed and staff had not always followed guidance relating to management of risks.

Relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns. Sufficient staff were deployed to meet people's needs and keep them safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles. However, the principals of the act had not been followed as mental capacity assessments had not been undertaken or regularly reviewed.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

People had access to healthcare services and people's nutrition was well maintained.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected the decisions they made.

The provider and staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although care plans were personalised and gave clear guidance for staff on how to support people they were not always up to date with people's needs.

Relatives knew how to raise concerns and were confident action would be taken. People's opinions were sought and they were involved in the running of the service.

People's needs were assessed prior to receiving any care to make sure their needs could be met. However, people's care needs were not regularly reviewed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have effective systems in place to monitor the quality of service. People's records were not robust or complete.

There was a positive culture and the manager shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff in the service. Staff knew how to raise concerns.

Coghlan Lodges Limited

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 and 3 November 2016 and was announced. We gave 48 hours' notice of the inspection because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be available. This inspection was carried out by two inspectors.

We spoke with six people who used the service, four relatives, two advocates and seven care staff. We also spoke with the manager and one of the directors of Coghlan Lodges Limited. In addition we received feedback from two healthcare professionals, Slough Borough Council (SBC) safeguarding team and the commissioner of services.

We looked at six people's care records, five staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which captures the experiences of a sample of people by following a person's care route through the service and obtaining their views about their care.

We reviewed information we held about the service, including notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Requires Improvement

Is the service safe?

Our findings

We identified a number of areas of concern at this inspection regarding the management of people's medicines.

One person who had been prescribed Warfarin was not managed safely. People taking Warfarin should have regular blood tests to ensure the correct dosage is administered. When the person has their blood test, another date should be scheduled and this date should be recorded on the person's care records. We found a recording in the handover book (a book which is used to handover information between shifts) for this person on 31 August 2016 which stated the dosage the person should receive. We asked the team leader how this information had been communicated to them. They told us it was by telephone. We asked if these changes had been confirmed in writing. They said it was only recorded in the handover book. Best practice dictates that changes to a person's dosage should be written, for example in an email, fax or in the person's Warfarin blood test book. This is because verbal changes contribute to the risk of errors.

The NHS National Patient Safety Agency (NPSA) guidance had not been followed. The provider was not correctly recording the changes to this person's dosage; they had not obtained a written confirmation from the prescriber and the provider had not included a specific section in their medication policy as per NPSA guidelines.

We saw the provider's medications policy did not contain a specific section on the administration of anticoagulant medication. The policy also stated when receiving verbal instructions, 'this must be by exception only' and before ending the call 'request written confirmation by fax, letter or by issue of a new prescription, without delay, and before the next administration of the medicine'. We discussed this with the team leader at the service and they were not aware of this requirement.

Another person who used the service was regularly absent when their medication was due to be administered. We saw this had occurred on three consecutive months, August, September and October 2016. Although we saw records to show this missed medication had been returned to the pharmacist, there were no records to demonstrate that a review of the impact to the missed medication had been undertaken for this person. The provider's medication policy states 'when a service user refuses medication, advice should be obtained from the prescribing GP in order to minimise medication risks. The medication this person missed belonged to a number of groups which if missed can have a detrimental effect on people's mood and wellbeing, The provider had failed to recognise the risks posed to the person by not taking this medication. There was no record of them alerting the GP of the missed medication or that a risk assessment had been undertaken to ensure the person received safe care.

We found medication administration records (MAR) were not always accurate as MAR charts had not always been completed or had been completed incorrectly. For example, we saw one tablet for one person was not in the person's dispensing box and the MAR chart had not been completed to show the medication had been administered. Another person was in receipt of paracetamol. However, it was not clear from the records if this medication was prescribed or was a PRN (as required) medication. This person's prescription

stated two tablets four times a day. However, this person had not received the medication on one occasion on 2 November 2016. Therefore it was not clear and records did not show if this person required this medication on a regular basis or on a required basis. We found the number of tablets held in stock for another person did not tally with the MAR chart. The MAR chart showed a balance of 72 tablets, however, there were only 70 tablets in stock. There was also a further discrepancy in the records as this person had only received one tablet on 2 November 2016 and not two tablets as prescribed. We discussed this with the team leader at the service; they were unable to provide a reason for the error and agreed the records were incomplete.

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

People's medicines were stored safely. We saw in most cases people received their medicines as prescribed. Records confirmed staff that assisted people with their medicine had been appropriately trained and their competency had been regularly checked. However, this training was not always effective. People and their relatives told us they received their medication at the times they needed it.

People and their relative's told us people felt they were safe. One person said, "I feel totally safe, if I had any concerns I would tell [name, team leader]. Relatives comments included; "Definitely safe, very pleasant environment"; "If [name] did not feel safe, they would let me know if something was wrong"; "He is safe as this is where he feels comfortable" and "Coghlan Lodges do well as there are not many places that can look after [name] safely". A health professional commented; "I feel that service users are safe and settled in their accommodation. Risk is fully assessed and they work closely with Care Co-ordinators in order to support people".

People were supported by staff who could explain how they would recognise and report potential abuse. Staff told us they would report concerns immediately to their manager or team leader on duty. Staff were also aware they could report externally if needed, for example to the Care Quality Commission (CQC). Staff comments included; "I would report any concerns to the manager or the client's social worker" and "I'd raise my concern with my line manager. If there was nothing done, I would take it higher in the organisation". Staff were aware of the Whistle Blowing policy. One staff member said "Whistleblowing it important, it uncovers things others may not see". The service had systems in place to investigate concerns and report them to the appropriate authorities.

Risks to people were managed and reviewed in most cases. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, people's behaviour and how to manage them including techniques to de-escalate incidents. Care plans showed regular reviews had been undertaken by the manager.

We noted that people's care plans did not include a contingency plan in case of emergencies, for example, evacuation plans. We discussed this with the team leaders and they agreed to include a section to identify people's individual needs, including mobility, in people's care plans.

There were systems in place to record accidents and incidents and staff we spoke with were aware of how to report these.

Staff and people's relatives told us there were sufficient staff to support people. Staff comments included; "There are enough staff. On occasions we get last minute sickness but even then we cover it"; "We let the manager know and he arranges cover for us", "The manager sends additional staff if we need it to cover

absences" and "Yes cover is provided and people are not at risk". We were told and the staff rota's confirmed that people were supported by agency staff to enable them to go out in the community. The manager told us agency staff are sourced from the same agency to ensure continuity of care for people.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised with people. These included employment references, Disclosure and Barring Service (DBS) checks and UK boarder agency checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions. We spoke with staff about their recruitment process. They told us they had completed application forms and had a formal interview before commencing in their role.

We received comments that some people struggled to understand staff. This had led to a miscommunication between the relative and the staff member. Another relative said "Sometimes I have problems understanding staff accents".

We looked at how people's money was managed. We saw records were in place to record when people were given their daily allowance, including the current balance of people's money held by the provider. However, we found one person's balance did not tally with the records. We were told by the team leader that this cash was an excess from the providers petty cash budget. They agreed to take immediate action to ensure the balance of cash tallied to the records. We found that when people's financial accounts were audited, these were not signed off to show an accurate record had been maintained.

Requires Improvement

Is the service effective?

Our findings

People were not being supported in line with 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.

We looked at four people's care files and although a reference was made to their mental capacity when initially assessed, we found that care plans did not contain any mental capacity assessments relating to specific decisions for people. We were told by the manager and team leaders that their understanding was that the mental health team were responsible for carrying out these assessments. Staff told us there were two staff members who had the specific training and skills to assess people's capacity. They said that these two staff members had not visited people for months to carry out any assessments.

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

We discussed the MCA with staff and the manager. They demonstrated an understanding of the rights of people who lacked capacity and were protected. One staff member told us "It's about empowering people to make decisions and recognising when they are struggling to make that decision". We saw staff offered people choices and gave them time to make decisions. These decisions were respected. Staff checked people could understand information and if unsure staff explained the choices for the person and the benefits. For example, best use of their money and the health option of walking instead of using transport. We saw people's consent was obtained, for example, consent for the provider to manage their finances.

People's relatives and professionals told us staff were well trained and supported people effectively. One relative told us; "Staff manage [name] very well, and know what they are doing to care for [name]". Professionals comments included "Service is very effective in supporting our service users to achieve their desired outcomes"; "Excellent work from Coghlan Lodges for helping [name], this is the best he has been in many years" and "This individual at times has been challenging and the staff have gone above and beyond to support him".

People were supported by staff who were knowledgeable about their needs and interests. Staff clearly displayed a very good understanding of people's individual needs. For example, one person required a Gluten free diet and the staff member explained how they assisted the person with shopping and choosing healthy food for them to eat.

People were supported by staff who had the skills to carry out their roles and responsibilities. Staff told us they received an induction programme which included a period of shadowing other staff to ensure they felt confident before working with people on their own. One staff member told us how they had struggled when they first started to work at Coghlan Lodges. They said they were well supported and was given more time to

settle into the role. Staff told us they received enough training to carry out their role and had the opportunity to ask for more training if needed. Comments included; "I feel very well supported with my training" and "I am well supported and the training is good". They told us they had received training in safeguarding vulnerable people, medication management and other specific training to look after people. This included managing challenging behaviour and 'break away' techniques when people became upset. One staff member said about break away technique training; "This was very very useful for me as I had not worked in this environment before". The training staff received was confirmed when we looked at the providers training matrix. The record showed when refresher training was due and forthcoming training dates for individual staff had been recorded.

However, one care workers file showed they had carried out several training programmes in one day, including practical training. We discussed this with the manager and they told us this was a recording error as the date on the certificate was the date it was issued and not the date the training had taken place. The manager and director agreed to review the process and request that certificates correctly reflect the training date.

Staff told us, and records confirmed, they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings, for example the environment people lived in. They said these supervisions were conducted in private and the manager would ask how they were getting on in their role. Staff also confirmed they received an annual appraisal. They said they were encouraged and asked to put forward ideas on how to improve the service. For example, one staff member told us how they had provided ideas of how to improve communication between staff. They said they were listened to and the provider had made improvements in communication.

Staff told us and records showed meetings took place on a monthly basis in services and between team leaders. Topics included accommodation, housekeeping and infection control. We saw a communication book was operated in services to ensure staff were kept up to date with any changes to people's needs on a daily basis.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, mental health practitioners and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans. One relative told us "[name] sees his GP when needed" they told us how one staff member had assisted their son to see their GP as there were concerns regarding his blood pressure. We saw one person was in the process of being supported by the mental health team to manage their behaviour. The mental health team were working with Coghlan Lodges to improve the person's safety. One professional commented "Coghlan have linked him into the local substance misuse services and he hasn't relapsed or come to the attention of the Police as he has in the past, and he continues to do well in the placement".

People's relatives told us they felt people had enough to eat and drink. Comments included; "It's his choice, his food and how he eats is monitored and supported by the staff"; "[name] has put on weight which is a good thing as he needed to". One person told us "The food is great here". Staff members told us how they assisted people to cook and make choices about their food. For example, how they encouraged the person to make a healthy meal choice option. They told us how they had supported the person to change their eating habit of having takeaway meals several times a week. They said they had taught them to cook and now the person really enjoyed cooking and now make their own decision about what to cook. The staff member said "It's a balance of choice, so we work with the person to stay healthy but still give them a choice

of a takeaway meal on a weekend for example".

Good

Is the service caring?

Our findings

People benefitted from caring relationships with their relatives and staff at Coghlan Lodges. We saw the relationship and interaction between staff and people was relaxed and supportive. Relatives comments included; "Definitely, [name] has a good relationship with staff, as much as he will allow them to. They care for [name] under very difficult circumstances at times" They also said "He sees his family and children when he is well enough, they all went away on holiday with me to celebrate an important birthday"; "I can see [name] when he wants me to, the relationship is good and can maintain family contact as I don't have the caring role anymore" and "In general [name] is quite content here".

Staff comments included; "The relationship has made a difference to this person's life"; "I have supported her to understand her situation regarding access to her children. I have helped her to understand her legal position and I encourage her to speak to the children on the phone twice a day. This has taken a lot of work, but we have got there"; "I have gradually introduced changes for the person, for example, walks, sitting in the park and going out in the car" and "We consider people's needs, personalities and age group before they come to live at the service. We try and set up a community feeling in the service, for example, encourage people to go shopping together and where needed, support from a staff member". One staff member told us how they had supported someone to move into their own flat, they said they are still in contact with the person and commented; "It is very rewarding to see people improve".

Staff also spoke with us about positive relationships with people. Comments included; "I take them out to lunch to build a relationship"; "I work with people and encourage them to follow their interests". One person told us "I feel very well looked after; I don't want to go anywhere else".

Staff we spoke with told us they would always use people's care plans to learn about their needs and preferences. One staff member said "It's (care plan) my first point of call".

One advocate (person appointed to represent the person's interest) told us; "I have visited a couple of times. So much better than his previous placement. His room is very nice and the staff and he seem to get on. He has very much improved since his previous placement".

When we visited the services, we saw people were empowered to make decisions for themselves. At one service people were sitting very calmly and quiet and were reading a newspaper at the table. One staff member said "We are trying to get people to live more independently".

People were free to come and go from the service where they lived. We saw staff engaged in conversation with people. They displayed genuine caring attitude toward the people. Staff told us how they supported people to make decisions as they helped one person get rid of their fear of doing certain tasks or events. They said; "I would give them reassurance, encouragement and facilitate them to make decisions"; "I like their lives to be full of potential and to encourage them to improve their lives so that they don't need so much support" and "We want people to flourish, we don't want anyone to relapse". Another staff member said "It's very important for [name] to look nice and wears nice clothes. Staff support this person as they are

vulnerable, but staff make sure they respect the person's wishes and only assist when asked. Another staff member said; "I will go swimming with [name], but I respect their independence as I keep my distance". One relative told us how their family member was encouraged to make decisions about support with their personal care. They said their family member was always asked by staff if they wanted assistance with their personal care or not and staff respected the person's decision if they refused.

People's dignity and privacy were respected. When staff spoke about people with us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. Staff told us when they were providing personal care in people's rooms, doors were closed and curtains had been drawn promoting their dignity. A relative we spoke with said, "Staff respect [name] independence, he has his own room now and he can go in and close his door to be alone and staff respect this".

We asked staff how they promoted, dignity and respect. One staff member said, "I always knock on people's doors, I ask before I go into their bedroom to make sure I show them respect". They told us how one person had not respected other people's feelings that lived at the same service. They told us how the person had reacted positively to the staff member's intervention and understood how their actions had upset other people. Another staff member told us how they recognised people's independence. They said; "I offer to accompany them and give them the choice, yes or no". They also told us how they respected people's decisions. One person had asked the staff member to write their shopping list. The care worker said "No, you do it. I give [name] her daily allowance and always get [name] to pay for things herself. It encourages her independence". Another staff member told us how they (Coghlan Lodges) encourage people to be independent. They said; "We encourage people to be involved in their interests, it better's people's skills" and "We always encourage people to make phone calls to keep in contact with their families and friends".

Staff ensured people's care plans and other personal information were kept confidential. People's information was stored securely in lockable cabinets. Staffs knew about the importance of keeping people's personal details confidential and were aware of the provider's policy on confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to receiving a service to ensure their needs could be met. People or their families had been involved in this initial assessment. Care plans contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and in most cases, religious needs. Staff we spoke with were aware of people's preferences. However, details we were told by care staff were not always reflected in the same detail in people's care plans. For example, one person had lived on a farm and they looked after horses. This person said it was important to them and how much they enjoyed the work. This same person had an injury to their right hand side of their body, but their care plan had it recorded as their left hand side. Another person had a specific phobia which unless managed carefully, caused anxiety. In both cases, this information was not reflected people's care plans. It is important to ensure accurate records are maintained to enable staff to respond to people's needs and wellbeing.

Care plans had a front sheet which had been signed and dated by the manager to show they had audited or reviewed the care plan. However, there was no record of people's involvement in reviews of their care. For example in one care plan we saw the last recorded review of this person's care was in 2012. We could not find any documented evidence to show a review had taken place since this date. People we spoke with confirmed this when we spoke with them. However, relatives and professionals said they were involved in people's reviews. One relative said; "I am fully involved with care and reviews of care. Along with the mental health team and the manager".

We saw a Recovery Plan was present in people's files; however these were not always signed or dated. Therefore it was not clear if the details had been reviewed and if they were up to date.

One relative commented how well their family member had been managed when they moved between services to another operated by Coughlan Lodges. They said "They managed [name] move quite well, they look after [name] challenges of daily living and always involve me".

Professionals told us Coughlan Lodges was responsive to people's needs. Comments included; "We have referred people who require a supported living placement and they will always assess in a timely manner and provide a full assessment and proposed care plan for us (health professional) to consider" and "At times he has difficulties sleeping at night and can be distressed, they are responsive and an extra member of staff was arranged to work nights to support him".

A 'key worker' system was operated at Coghlan Lodges. This is where an allocated care worker is designated to work with an individual person. The team leaders told us that they regularly had reviews with people and their care workers. However, this was not recorded in people's care plans. One team leader told us this is informal, we would ask if everything is ok and if the person wanted anything different. Some of these conversations were noted in the daily records, but not in people's care plans. Some documents were present which recorded conversations, but these were not dated or signed by the staff member or person involved in the review. One relative told us "They have a key worker system which works well. [name] has a

weekly session with their key worker and deputy manager".

We found people were encouraged and supported to maintain contact and relationships with their families. One relative told us how their family member is in regular contact with the family. For example, "[name] plays the guitar and so do his children; we encourage them to all play together". They said the service was responsive to [name] needs. "Sometimes I do not visit due to my son's mental health state, it's his choice, staff let me know if it is a bad time". Staff told us how they support people to celebrate a family birthday by encouraging the person to send a card and gift.

Professionals told us how people were encouraged to integrate into the community and maintain their interests. For example; "[name] can go into town on his own, has his own bus pass. Does his own cleaning, cooks own microwave food". This person told us, "I am quite independent, can meet my family, go shopping, look after my own money and my medicines".

Staff told us how they work with people to improve their social skills. One staff member said "There is a breakfast club on Wednesday and Saturdays for people to join in if they wish. We also have a roast dinner on a Sunday. Service users take it in turns to cook a communal meal. We heard how one person is a volunteer at the British Heart Foundation. Staff also gave examples of how they work with people to maintain their interests. For example, take people on holiday to the seaside and out for meals as individuals and as a group.

People and their families were provided with details of how to raise a complaint. For people who used the service, there was also a pictorial version of how to make a complaint. People told us "I have no complaints".

Staff we spoke with were aware of the complaints process and said they would listen to the complainant and try and address the concerns themselves. If the concern could not be resolved, they said they would raise the concern formally with their manager and record the details.

We saw a system was in place to record complaints. There had been one formal complaint since our last inspection. Records showed appropriate action had been taken and the family were happy with the outcome. One professional we spoke with commented; "There has been an occasion where the individual was being what he viewed as 'bullied' by another resident, the staff handled this matter very well and timely to support both parties involved and resolved this , I would recommend this service". One relative told us "I have never had an issue and I would call the manager if I had concerns. There was one occasion when I needed to discuss an issue. This was resolved to my satisfaction".

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 4 and 5 August 2015 we found the provider had failed to notify the CQC of significant events. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. We also found concerns relating to the recording of medication and financial transactions for people. This was a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our August 2015 inspection the provider sent us an action plan telling us how they were going to meet their legal requirements.

At this inspection we found the provider had made the necessary notifications to the CQC. Some improvements had been made in the recording of financial transactions, but there were still some inaccuracies in people's finances. We still found concerns regarding the management and recording of people's medicines.

We saw copies of audits at the providers' head office. For example, care plans and medication audits. Areas for improvement had been identified by the manager, for example, monthly care plan evaluations not being completed and MAR records not dated or signed and there were gaps in MAR's recordings. The medication audit undertaken in July 2016 identified a 'high priority' action for staff. It stated 'All staff to make sure they put their initial on the MAR's after administering medicines'. This area of concern was identified at this inspection. This meant these audits were not effective as staff had not taken the necessary actions to make improvements to records.

Systems in place to check the quality of care were not effective. Records for people who received anticoagulant medicines were not maintained to ensure the correct dosage was recorded and the team leader had accepted verbal updates regarding the change to the person's medication. The team leader had failed to follow the NHS National Patient Safety Agency guidance. The provider had also failed to ensure their policies reflected good practice guidance to ensure the safety of people who were in receipt of anticoagulant medication. We also found the provider had not taken the appropriate action, or reported to the person's GP, when this person had consistently failed to receive their medication. The provider and manager had failed to monitor and quality assure the medicines records within the service. make improvements to their monitoring systems to ensure they had a robust monitoring process in place. They had failed to identify failings in the management of medicines and take the necessary action to protect people.

Financial recording for some people had improved. However, we found one person's recorded balance did not tally with the cash held by the service. We also found records were not well organised or clearly structured as when audits of people's accounts were carried out; these were not always signed off by the auditee as a true record. It was also unclear who had delegated responsibility for people's finances as we saw in some cases the local authority had carried out the audits of people's accounts.

The provider had failed to record changes to people's care in their care plans. For example, key worker meetings. Although some records were available, these had not been signed or dated. Some people's

records had not been updated following discussions with the team leader. This meant records maintained did not accurately reflect people's current needs of care.

The manager told us they regularly reviewed people's care records. This was confirmed in some of the care plans. However, we were not assured that good governance was in place as records held for people were not always accurate and the provider did not demonstrate they were monitoring the quality of the service effectively.

We were told surveys to measure the quality of the service had been undertaken in 2016. The manager said family surveys took place in June, staff and quality of food provision surveys had taken place in July 2016. We saw overall relatives, people and staff rated the service as Good or Very Good. Comments included; 'Good care given at all times. I am very proud of [name] as there had been great improvement during his time at (service) and 'Excellent service, this is what my son always needed, supportive staff'. However, although the surveys were present they had not been dated so it was not clear when these had been undertaken. Also, we found duplicated forms in the staff survey, so there was the potential of 'double counting' of the responses. One person and a relative told us they had not been asked to provide feedback about the service.

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

People knew team leaders, the manager and the provider. People approached team leaders with open familiarity and called them by name. We saw people were well at ease in their company and were open in their conversations. For example, discussing their plans for the day. One person described what it was like to live at Coghlan Lodges, they said "Relaxing".

Relatives and professionals knew the manager and spoke with us about how the service was managed. One relative commented; "If there is any incident with [name], key worker will call me straight away" and "I am definitely informed of any change by the manager or key worker". One professional said; "I visited one of the services and was impressed by the management team (directors) who explained how the business started and their backgrounds, which were all in mental health, substance misuse and forensics". Another professional said; "I continue to be impressed and I am happy to endorse Coghlan Lodges".

Staff comments included; "Our (staff) opinions are valued, they recognise staff know what works best for people"; "We (staff) are invited to join the manager at family meetings, so yes, we are involved"; "They (manager) listens, provide good support when you need it and encourage change"; "Very supportive, especially when an incident has occurred"; "Very open culture, I can phone for help or advice at any time, even at 1am in the morning"; "I am asked for ideas and opinions on how the service is running and they listen to ideas on how to improve" and "I would rate the support from the manager as 3.5 out of 5".

We saw minutes of meetings between family members, key workers and the manager. These were comprehensive and discussed the person's individual needs. For example, medication changes. These meetings were both planned and impromptu which demonstrates the manager is willing to make themselves available to people's families. This was confirmed when we spoke with relatives.

Coghlan Lodges did not have a registered manager in post. The position had been vacant for over 12 months. We discussed this with the provider and the manager. They told us this was due to the manager awaiting their result of their DBS. We were told they would be putting an application into the CQC to register the manager immediately.

One professional said about the management; "They understand risk and work with us to support some of our service users who have extremely high needs".

Relatives said about the management of the service; "In general, not badly run. An improvement on previous providers"; "They are dealing with [name] and associated problems in the best way they can. His life is better, family feel less worried due to the support provided by Coghlan Lodges and family support".

Staff comments about the management included; "The manager is very down to earth, approachable and easy to talk to" and "They make our work a lot easier as you know you will be supported".

Services are required to display their most recent ratings on their website and at the provider's principle place of business. Ratings of the August 2015 inspection were not displayed on the services website or in the office. We discussed this with the manager and the provider, they took immediate action on the day of the inspection and we have confirmed they have displayed their most recent CQC report on their website. We have asked the provider to ensure the summary from the inspection in 2015 is available for people in their services.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to follow the principals of the Mental Capacity Act (2005) and associated code of practice. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not administered accurately and risks associated with incidents that affect the health, safety and welfare of people were not safely managed. The provider had not complied with relevant Patient Safety Alerts. Regulation 12 (2) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust systems were in place to identify where quality and or safety had been compromised. The provider had not identified the risks to people's health, safety or welfare of people. The provider had failed to maintain accurate contemporaneous records in respect of each service user. Regulation 17 (2) (a) (b) (c)

The enforcement action we took:

Warning Notice