Valeo Limited

Trabel

Inspection report

26-28 Cambridge Road
Huddersfield
West Yorkshire
HD1 5BU

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09 August 2016

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

Summary of findings

Overall summary

This inspection took place on 9 August 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Trabel House in January 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Trabel House is a care home for 12 people with learning disabilities and associated challenging behaviours. There were 12 people living in the home at the time of this inspection.

The service had a registered manager. 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 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 were kept safe from harm. Staff were aware of the different types of abuse people might experience and of their responsibility for recognising and reporting signs of abuse. Possible risks to the health and safety of people using the service were assessed and appropriate actions were taken to minimise any risks identified.

Robust staff recruitment processes were in place to ensure applicants were properly assessed as to their suitability for working with vulnerable people. There were sufficient staff to safely meet people's needs and staffing was well organised to ensure people received appropriate levels of support.

We found some of the systems in place to ensure people received their medication safely were not effective and could have put people at risk. We recommended the service review its medication audit to ensure it was robust enough to identify any issues in relation to the safe administration of medication.

Staff had been provided with ongoing training and support to assist them in performing their role. Although we found supervisions were not always undertaken in line with the provider's policy, staff we spoke with told us they felt well supported and had the necessary skills needed to care for people effectively.

The service worked within the principles of the Mental Capacity Act 2005 (MCA) to uphold people's rights. Detailed information was held about how to communicate effectively with people in order to maximise their ability to provide their consent to care and treatment wherever possible.

People using the service were supported to meet their nutritional needs and to maintain good health through access to appropriate healthcare services.

Staff demonstrated a sensitive and caring manner in their interactions with people using the service. They were knowledgeable about people's needs and how best to support people to be as independent as possible.

People and their relatives were involved in care planning and were actively encouraged to share their views and opinions of the service. People's privacy and dignity was maintained.

Care plans were reviewed and updated on a regular basis to reflect changes in people's needs. Input was sought from healthcare professionals to ensure people were receiving care and treatment which was appropriate for their needs. Care records were person-centred and provided staff with information about how to care for people in line with their individual preferences. People's wishes and aspirations were clearly identified and they were supported to achieve these.

The service had appropriate systems in place for recording and responding to complaints and records showed complaints were taken seriously and thoroughly investigated.

Information was provided to people and their relatives about who to contact should they have any concerns. Staff we spoke with felt supported by the registered manager and were able to easily access support when they required it. The provider had a range of systems in place for monitoring and reviewing the service and action was taken to address areas for improvement.

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. The arrangements for supporting people with their medication did not fully guarantee their safety.

People were protected from harm. Staff were aware of the signs and symptoms of abuse and their responsibility for recognising and reporting these.

Risks to people were assessed and appropriate measures taken to keep people safe from harm.

There were sufficient numbers of staff to meet people's needs safely.

Is the service effective?

Good

The service was effective.

Staff were provided with support in terms of training, supervision and appraisal.

Consent to care and treatment was sought in line with appropriate legislation. Best interest decisions were made on people's behalf where necessary.

People were supported to meet their nutritional needs and to access healthcare services when required.

Is the service caring?

Good

The service was caring.

Staff demonstrated a sensitive and caring manner in their interactions with people. Staff were very knowledgeable about the people they supported and were able to provide care to people in a way that met their individual needs.

People's privacy and dignity were respected.

People were treated as individuals and encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and reviewed on an on-going basis. Care provided was person-centred and changes in people's needs were responded to promptly.

The service had an appropriate system in place for recording and responding to complaints.

People were regularly asked for their feedback on the service and information provided by people was used to tailor their care to their individual needs.

Is the service well-led?

Requires Improvement

The service was not always well-led. Although systems were in place to monitor and develop the effectiveness of the service, these were not always full effective in identifying all areas for improvement.

At the time of the inspection the service had a registered manager in post. Staff spoke highly of the registered manager.

There was an open culture in the service that sought the views of people, relatives and staff.

Trabel

Detailed findings

Background to this inspection

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

This inspection took place on 9 August 2016 and was unannounced. This inspection was undertaken by two adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

During the inspection we toured the building and talked with two people who lived in the home and one visitor. We also spoke with staff including the registered manager, the deputy manager, three senior support workers and three project workers. We reviewed a sample of four people's care records, five staff personnel files and other records relating to the management of the service. We also undertook general observations in communal areas.

Requires Improvement

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. A relative we talked with told us their family member, who had self-harming behaviour, was kept safe at the home.

We looked at the management of medication. We were informed the service had recently changed to a new supplying pharmacy following a number of issues around supply with the previous one. We observed the lunchtime medication round and spoke to one of the senior support workers about medication administration.

With the exception of four people using the service, people's medication was kept in a locked cabinet in their room. The senior support worker explained when they were due to administer medication to a person using the service they would either accompany the person to their room or ask them to come to the medication storage room, depending on where their medication was stored. Each person using the service had their own medication folder which contained all documentation in relation to the person's medication. People's Medication Administration Records (MARs) were checked on a weekly basis to ensure people were receiving their medication as prescribed. Any issues identified during these checks, such as missing signatures or discrepancies on medication tally sheets were recorded and highlighted to the registered manager for investigation.

We looked at two people's medication folders. We found these people were prescribed creams and ointments which support workers applied. The MARs for these people provided some guidance to staff on the application of these preparations. However body maps were not contained within these people's records with clear directions for staff on how to apply these preparations. This meant there was a risk that staff did not have enough information about what creams were prescribed and how to apply them. We also found a cream in one person's room which was not recorded on the MAR and creams and ointments were not being labelled with the date they had been opened. This meant there was a risk that staff were applying these creams and ointments when it was no longer safe to do so. Following the inspection we were informed by the registered manager that body maps had been introduced for these two people and the cream which was not on the person's MAR chart had been returned to the supplying pharmacy for safe disposal.

We asked the registered manager about the support provided to staff who administered medication. We were told staff received medication training and their competency to administer medication safely was assessed on a six monthly basis. We viewed the records in relation to this and found not all staff had been receiving regular six monthly competency assessments. We highlighted this to the registered manager who agreed checks had not always been completed within six months and took action to ensure arrangements were in place to prevent this from happening again.

We found daily temperature checks were being performed in all locations where medication was being stored, including people's bedrooms. With the exception of the medication storage room on the ground floor of the home, we found temperatures were within safe ranges. The records indicated the temperature

within the medication storage room had on occasion exceeded 27°C. We highlighted this to the registered manager who agreed she would look into how this could be improved. Following the inspection we were informed medication was no longer stored in this room and that cabinets had been placed in each person's room for the storage of their medication. The service did not have a medication fridge. We were advised any medication that needed to be stored in a fridge was stored in the kitchen fridge in a separate locked box.

We considered that the service was failing to protect people using the service against the risks associated with the unsafe use and management of medicines.

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

The provider had a safeguarding policy and procedure in place. These documents provided details of the provider's responsibility for recognising and reporting abuse. Guidance was provided to staff on the different types of abuse and the signs and symptoms people being abused may display. Staff we spoke with were aware of their responsibilities for recognising and reporting any concerns or suspicions of abuse and had received training in relation to safeguarding.

We asked to review the service's safeguarding log. We were told details of any safeguarding incidents were held within people's individual records and that an overall log was not maintained. We reviewed the records for two people using the service for whom safeguarding incidents were recorded. We found appropriate action had been taken by the provider on both occasions. We suggested the registered manager consider introducing a safeguarding log to provide them with an overview of all safeguarding incidents occurring within the service and enable them to identify any patterns or trends. Following the inspection we were informed by the registered manager that they had introduced a safeguarding log.

The service also had a whistleblowing policy and procedure in place and staff we spoke with were aware of this. Information about the whistleblowing policy and procedure was on display in the home. Staff we spoke with told us if they had any concerns they would report these to the registered manager. One member of staff also explained how if they were not satisfied with the registered manager's response they would report their concerns to the provider or to other agencies such as the local authority or the Care Quality Commission.

We saw that people had very detailed assessments of their capability to manage their personal finances, and where applicable plans for any support required. Money held for safekeeping was suitably accounted for in records of transactions which were confirmed by associated receipts. We noted that not all entries were witnessed when signed and brought this to the attention of senior staff for future reference. Cash and balances were checked daily to make sure each person's money was being handled safely.

We reviewed the service's health and safety folder. This contained individual risk assessments based on tasks undertaken by staff, for example handling clinical waste or manual handling. Risk assessments were reviewed and updated on a regular basis and actions taken to minimise risks were clearly recorded.

The service had a separate Control of Substances Hazardous to Health (COSHH) folder which contained individual risk assessments and risk management plans for each of the different substances, such as cleaning materials used within the service. We found the COSHH folder was kept on the top floor of the home and was therefore not readily available to staff dealing with these substances on a daily basis. We discussed this with the registered manager who agreed copies of the information contained within their folder would also be kept in the laundry and kitchen so that it was more accessible to staff.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and water temperature and quality were undertaken. The service also had contracts in place for the routine maintenance and servicing of equipment.

Suitable measures were taken to reduce identified risks and keep people safe during their care delivery. The staff we talked with had a good understanding of people's vulnerabilities and the best ways of managing risks to their safety and welfare. Risks to personal safety had been thoroughly assessed, including whether the person was vulnerable to abuse, exploitation and posed risks to themselves or others. Risk management plans covered areas such as kitchen safety, risk of choking, preventing accidents and falls, and safety when out in the community. Extensive 'safeguarding and conflict management' plans had been devised which described the strategies for managing potentially harmful behaviours. Each person also had a plan in the event of emergency circumstances to support them in being safely evacuated from the home.

We spoke with the registered manager about staffing levels. We were advised staffing levels were calculated based on the level of support required by people using the service. Staff rotas were produced on a monthly basis by one of the senior support workers and took into account people's individual needs. For example where people using the service required one to one or two to one support this was clearly accounted for in the staff rota.

We asked the registered manager about the arrangements for emergencies and out of hours cover. We were told there was an on call rota in operation and we saw details of the staff member on call each day clearly highlighted in red on the rota. Relevant contact numbers for those staff members responsible for undertaking on call duties were kept throughout the building for staff members to refer to. The registered manager told us they had their own bank staff who they could use to cover sickness absence or other emergencies but that they did on occasion use agency staff. The registered manager told us the service had a relationship with an external agency and that continuity of care was achieved through the use of the same agency staff members. Agency staff members received an induction prior to starting work at the service and were provided with a 'service user analysis needs' document. This provided them with an overview of each person's needs and details of how to support them. This document was designed to assist agency staff in quickly becoming orientated and familiar with people and their needs and how best to support them.

During our visit we observed there were enough staff on duty to safely meet people's needs. We saw people who required two to one or one to one support received this. The senior and project workers we talked with told us the staffing levels were sufficient to enable them to care for people safely.

We reviewed the staff files for five staff members who had been recruited by the service in the last two years. We found potential staff members were asked to complete an application form which covered areas such as their previous experience and qualifications, a full employment history and details of two referees. Appropriate checks were undertaken with the Disclosure and Barring Service (DBS) to establish whether staff members had a criminal record. Two references had been sought in all of the files we reviewed and people's right to work in the UK was also checked.

We found all potential staff members had been interviewed by two people and the questions staff were asked during interview were different depending on the vacancy for which they were being interviewed. For example, those applying for senior support worker roles were asked about how they would deal with difficult situations between staff members or people using the service or what action they would take if they witnessed something inappropriate. Whereas those applying to be support workers were asked more generally about their understanding of learning disabilities and challenging behaviour and what action they

would take if a person using the service told them about a personal issue but asked them not to tell anyone. Overall, we found the service had robust systems in place for the recruitment of new staff members.

Good

Is the service effective?

Our findings

A relative we talked with indicated they felt their family member was well cared for at the home. The home's latest survey findings also showed that people and their families were positive about the support provided.

New staff received induction training to prepare them for their roles which was aligned to the 'Care Certificate'. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. Thereafter, staff were given a mix of classroom-based and e-learning mandatory training in safe working practices, safeguarding adults and handling medicines. Other training topics provided included equality and diversity, person-centred thinking, and mental capacity law. Courses specific to people's needs had been undertaken such as conflict management, caring for people with epilepsy and alternative communication methods.

At the time of the inspection a matrix, with an overview of the training completed by the staff team, was not fully up to date. Training lists within individual staff records were also in need of updating to correspond with certificates which verified the courses undertaken. We highlighted this to the registered manager who agreed to update these records and send us an updated copy of the training matrix following the inspection. This showed the majority of staff members were up to date for training in mandatory subjects such as safeguarding and manual handling.

There was a delegated system for providing individual supervision and annual appraisal to support staff and review their performance and training. The registered manager acknowledged that the frequency of five supervisions a year was not always being achieved. They told us they were taking steps to review the frequency and keep checks on the schedule of supervisions conducted by the deputy and senior workers. The senior and project workers told us they were well supported and given training appropriate to their roles and the needs of the people living at the home.

Many of the people who used the service had complex needs, including challenging and distressed behaviours. The service did not advocate the use of excessive control or restraint and trained all staff in de-escalation techniques and minimal physical interventions as a last resort. A senior worker gave us clear accounts of the ways staff worked with people, with an emphasis on recognising triggers to prevent behaviours occurring. This approach was confirmed in risk management plans and the monitoring and analysis of incidents.

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).

We found the service worked within the principles of the MCA to uphold people's rights. A good level of information was obtained about people's individual communication methods, their abilities to understand and make decisions about their care and if they were able to agree to their care plans. Details were also recorded about how a person's actions would demonstrate to staff that they were not consenting to the care proposed.

Formal processes had been followed to assess mental capacity and for decisions to be made in people's best interests. The decisions were focused on living in the care home, having care needs met, and specific areas of care provided such as medicines administration and support with finances. Most of the people living at the home had DoLS authorised to ensure they received the care they needed. A reminder system was in place for when DoLS were due to expire that enabled applications to be monitored and extended.

Detailed assessments were completed in relation to people's nutritional needs. These included the person's dietary preferences, any support required with eating and drinking, and, where applicable, involvement in shopping and food/drink preparation. People's weights were checked monthly and advice was sought from dietitians and speech and language therapists when people were assessed as being nutritionally at risk.

The role of project workers included cooking duties and they were given training in nutrition and food safety. There was regular, often daily food shopping for fresh ingredients. Staff told us they promoted healthy eating and supported one person to adhere to a special diet for religious reasons. Regular drinks and snacks were provided between meals and at mealtimes we observed that staff checked and replenished drinks.

The menus were compiled with input from people living at the home and included their known food preferences. Choices of meals were offered and staff said alternatives could be readily prepared if anyone wanted a different meal. Themed nights were incorporated into the menus, for example, Italian food and birthday celebrations. Barbeques were held in the garden when the weather was good. People also ate out regularly in cafes, pubs and restaurants with support from staff. Those people we spoke with who were able to express their views told us they enjoyed the food. One person said, "It's very good" and another commented that staff made "nice cakes".

People living at the home accessed a full range of health care services. Two local GP practices were used and most people attended the surgery, as needed. Annual health checks were carried out by GPs and specialist mental health support was provided by psychology and psychiatric services. Arrangements were made for people to have routine appointments with a local dentist, optician and podiatrist. One person we talked with told us, "I'm keeping very well."

Care records showed all contact with external professionals was documented, including any treatment, advice and changes to medicines. We saw evidence that staff were vigilant to people's well-being and sought medical attention promptly when health concerns arose. The registered manager told us everyone living at the home had their care partly funded by the NHS and therefore people's health care needs were usually reviewed annually. People and their families had also been consulted about end of life care and treatment, including wishes in relation to being resuscitated.

Good

Is the service caring?

Our findings

A person we talked with told us they had good relationships with the staff, particularly their keyworker. They said, "I like living here." A relative we spoke with indicated that staff were kind and they had no concerns about the way their family member was treated.

We noted a warm, inclusive atmosphere in the home. We observed staff were polite, friendly, patient and caring in their approach to people and their relatives. We observed staff carried out their tasks in an unhurried manner. Relationships between staff and people in the home were clearly based on mutual respect and affection. Staff and people appeared at ease in each other's company and smiled and interacted freely. The staff spoke respectfully to people and were also sensitive to individual's needs, for example, in quickly reassuring and comforting a person who became upset.

When people joined the service, they were provided with a "service user guide" which was personalised to them. This provided people with information about what they could expect from living at the home and what to do if they were unhappy with anything. It also contained information about advocacy services and encouraged people to be involved in providing feedback to the home so that it could improve.

The service aimed to support people to express their views and gave them information about their care in a way they could understand. Key policies, such as complaints and safeguarding against abuse were made available in easy read formats. These policies were also explained at monthly 'service user meetings' where staff asked about any concerns and if people felt safe living at the home. Other areas discussed included whether people were happy at the home and any suggestions for activities and the menus. Each person's response was noted along with any tasks or issues for staff to follow up on. Where able, people were involved in planning and reviewing their individual care and support. Feedback about satisfaction with the service was also sought from people and their families in annual surveys.

It was evident that routines in the home were flexible and this was balanced with giving people structure to their days. Staffing was well-organised, with project workers being allocated to work with individuals within the home and accompanying them to go out into the community. A senior worker described how they forward planned rosters to accommodate people's diverse needs. They ensured experienced staff consistently worked with people with complex needs and arranged for each person to have time with their designated keyworker. The registered manager explained that at particular times, such as when a person visited their family, two staff were always assigned to provide additional, safe support.

We saw staff were mindful of supporting people in a calm way when preparing them for activities. For example, a project worker helped a person to dress appropriately for going out and told us they were taking snacks as a means of redirecting the person if they became anxious. In another instance, a project worker was spending what they termed 'relaxation time' with a person prior to them going out for a drive and to have lunch.

We observed that staff worked inclusively and involved people as far as reasonably possible in the daily

running of the home. Some people went food shopping and, where able, made their own drinks and snacks and took their dishes to the kitchen after meals. One person told us they had been out with staff and had bought potatoes to go into a pie that was being made for the evening meal. At lunch we saw that the staff dined with people, ensuring they were supervised and supported with eating and drinking, where needed. Independence was encouraged and some people used plate guards which promoted dignified eating by preventing food spillage. Overall, the mealtime was a relaxed and sociable experience.

Staff we spoke with were aware of the need to involve people in their care and we observed people being offered choice throughout the inspection. We observed staff knew the people they were caring for well and were able to describe the best way to communicate with them and assist them to make decisions. Care records we reviewed provided information to staff about areas where people required assistance and guidance about how to support people.

Staff told us they encouraged people to make day to day choices about their support. They gave examples of offering personal care at times to suit the person and supporting people to choose their clothing, meals and social activities. Some people were unable to express their views and their relatives advocated on their behalf. A number of people also received support from Independent Mental Capacity Advocates when important decisions about their care needed to be made.

Staff we spoke with were also aware of the need to maintain people's privacy and dignity and were able to give examples of how they would do this. One staff member told us how medication was always administered in private, either in the person's bedroom or the medication storage room. Another staff member told us how if a person was incontinent they would direct them to the nearest bathroom and ask another member of staff to get some fresh clothes from the person's bedroom. During the inspection we observed good practice, for example we saw staff knocking on people's bedroom doors prior to entering. We also observed a staff member responding promptly where a person had ripped their clothing and this had resulted in their dignity being compromised. The staff member directed the person to their bedroom where they checked they were okay before assisting them to choose some new clothing. Staff were also aware of the need to maintain confidentiality and people's records were locked away and could only be accessed by staff members. Care planning included aspects of preserving people's privacy and dignity. For instance, there was information for staff about how to sensitively protect a person whose behaviour impacted on their appearance. We noted however, a notice displayed on the front door named a person living at the home and compromised confidentiality. The registered manager agreed that this would be removed or anonymised.

Good

Is the service responsive?

Our findings

A relative we talked with told us they visited regularly and that the staff were good at keeping them informed about their family member's welfare.

We found that people's care was planned in a person-centred way. Life history information had been obtained, helping staff to become familiar with the person's background and personality. Care and support needs were thoroughly assessed and set out in personalised care plans. The care plans addressed the person's independent skills, preferred routines and the support required from staff with their physical and emotional well-being and personal care. A summary of each person's care needs was provided to new project workers, bank and external agency staff to ensure that continuity of care was provided.

Guidance was recorded for staff about people who did not communicate through words, or had limited speech. For example, specifying where a person had difficulty in making their needs known and how to interpret their actions when they were feeling upset or in pain. Personal records were also supplemented by photographs and pictures to aid people's understanding of their care planning.

All care plans were evaluated monthly by staff, with the involvement of the person wherever possible. In addition people had quarterly meetings with their keyworkers where they were asked how they felt about living at the home; any skills they wanted to learn; holidays and activities; relationships and family contact; and any concerns or complaints. The meetings were monitored by the registered manager, deputy and senior workers and used as a further means of actively planning care throughout the year. Extensive annual reviews of care were also held to look at each person's progress and to set short and longer term goals to be achieved.

Information had been gathered about each person's lifestyle, preferences and interests. One page profiles were in place with guidance for staff on what was important to the person, the best ways to work with them, their goals and dreams and what they liked to do. For example, one person's profile stated, 'I love going out into the community, especially the pub'. This was supported by further details of the social activities they enjoyed and a forward planned timetable that included regular trips into the local community. Another person's profile showed they wanted to travel and have more holidays. We saw that they, and the other people living at the home, were given opportunities to go on day trips, short breaks and holidays. Destinations this year had included Skegness, Blackpool, Wales and Spain.

Staff told us each person had their own planned weekly activities, which for some included attending a day centre and social clubs for people with disabilities. A project worker said staff often tried out different activities to see if people enjoyed them and that there were spontaneous activities, such as holding party and movie nights. During our visit we observed that people were supported individually to do activities in the home and go out. Good use was made of amenities in the local and wider area including a park, shops, café and pub. A senior worker told us staff assisted people to maintain contact with their relatives, including buying cards and gifts, and to visit and, at times, have overnight stays in the family home.

The complaints procedure was in an easy read format with pictures and was routinely discussed at 'service user meetings'. No complaints had been made by any of the people present who were able to verbalise or otherwise indicate any concerns. There had been no complaints about the service in the past year. The registered manager was clear about their responsibilities to respond to and investigate any concerns received. This was confirmed by the last complaint, made in March 2015, which had been taken seriously, looked into and was subsequently withdrawn by the complainant.

We asked the registered manager to send us a copy of the 'service user guide' following the inspection. The guide encouraged people using the service to speak to a member of staff if they were unhappy with anything. It also contained a 'charter of rights' which explained what people should expect from the service. Information was provided to people about who they could contact if they were unhappy with the service they received, although contact details for outside agencies were limited. We discussed this with the registered manager following the inspection who agreed the guide could be updated to included additional information for people using the service.

Requires Improvement

Is the service well-led?

Our findings

The staff we talked with described good morale and teamwork. One staff member commented, "It's a good company to work for." Another expressed their appreciation of the support they had been given by the registered manager and deputy during difficult personal circumstances. We saw an external professional had documented a compliment about the service which read, "Good providers are hard to find."

The service had a registered manager in post who was aware of their role and responsibilities. The registered manager was supported in their role by the deputy manager. Support was also provided by the locality manager and the provider, with regular visits being undertaken to assess the effectiveness of the service. The registered manager had also delegated responsibility in some areas to senior support workers to assist in the management of the service. All staff members we spoke with told us they felt supported by the registered manager and would feel comfortable approaching her if they had any concerns.

The service had a person-centred, open, inclusive, empowering culture. Information provided to people using the service encouraged them to raise any concerns immediately with a member of staff. People using the service were encouraged to provide feedback and to be involved in making improvement through regular reviews with their keyworker and participation in residents meetings.

The registered manager told us the service had recently trialled a new method of engaging with people known as 'snacks and chats.' This had involved people meeting with residents from other local services which were owned by the provider to discuss the care they received and how this could be improved. The registered manager told us this had proved to be a very positive experience for all involved and was something the service was looking to expand upon in the future.

We asked the registered manager about the duty of candour. The registered manager confirmed they had introduced a policy and procedure in connection with this and they were aware of their roles and responsibilities under this.

Records we reviewed indicated senior support worker meetings and all staff meetings were held on at least a monthly basis. We found there was a clear record of the topics discussed during these meetings, with staff being reminded of expected standards of behaviour and practice and informed of areas for improvement. Minutes from the senior support worker meetings showed staff were reminded of their roles and responsibilities, for example through the completion of supervisions or medication checks and expected standards of behaviour were also reinforced. For example during the senior support workers meeting in April 2016, staff were informed incident forms from "events and untowards" were turning up several days afterwards and were reminded of the importance of completing these promptly and "putting them in the tray to be signed off." Areas covered during all staff meetings included; shift swaps, sickness and absence, incidents and untowards, care plans, policies and procedures and updates in connection with people using the service. We found topics were covered in adequate detail and informed staff of expected standards of behaviour and work.

The provider had a range of systems in place for checking the quality of the service. These included the completion of monthly checks of equipment and different areas of the home, regular reviews with people using the service and internal audits. Compliance and monitoring visits were also undertaken by senior management on a regular basis. Issues or areas for improvement identified were captured on the service development plan. Completion dates were allocated and progress was monitored on a quarterly basis. We saw evidence action was being taken to resolve issues or areas for improvement. For example the service development plan indicated the need to ensure staff were aware of and understood the MCA. This had been discussed with staff during the May 2016 staff meeting with them being asked to refresh their knowledge of the service's policies and procedures in relation to this. Another example was that people using the service were to be encouraged to personalise and update their bedrooms. The action plan indicated this work had started to take place and staff we spoke with confirmed this.

We discussed the issues we had identified in relation to the safe management of medication with the registered manager. The registered manager confirmed regular audits were performed to ensure the administration of medication was safe. We were told creams and ointments should be labelled with the date they were opened and that full instructions should be contained within people's medication folders for the administration of these topical medications. The registered manager also told us she was aware that the temperature within the medication storage room sometimes exceeded 27oC and that staff managed this as best they could by opening the window and closing the blinds to try and reduce the temperature. We found that although the service had audits in place to ensure the safe administration of medication, issues were identified during the inspection. This meant the service's audit was not robust enough.

We therefore recommended the service review its medication audit to ensure it is robust enough to identify any issues in relation to the safe administration of medication. Following the inspection we were informed by the registered manager that a new medication check had been introduced and would be used on a monthly basis. We were also advised action had been taken to address the specific issues in relation to medication which we found during the inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines.