Healthlinc Individual Care Limited

# Bradley Apartments

**Inspection report**

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## Ratings

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| **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** |

## Overall summary

We undertook this unannounced inspection on the 28 January and 2 February 2015. This was the first inspection of this service; it opened on 29 May 2014.

Bradley Apartments provides nursing and personal care to a maximum of 14 younger adults with a learning disability, some of whom may also have needs associated with their mental health and this may include needs that could not be met within a care home setting.

On the day of the inspection there were four people using the service. Another person was visiting the service as part of their structured assessment and transition programme to support their admission.

The service comprises of several small apartments with kitchens and living areas on the first floor, there is an activity room and lounge area on the ground floor. The service is located on the same site as Bradley Woodlands Hospital. Bradley Apartments has an allocated garden area in the grounds.

# Summary of findings

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Although we found some people had detailed and personalised care plans in place, the standard of recording was inconsistent and we found some people's needs had not been fully assessed and planned. This meant there was a risk they may not receive all the support they needed and in the way they preferred.

We found there were a range of safety systems and checks in place on the premises and equipment. However, we identified some concerns in relation to the management of the water systems and fire safety systems, which meant there was a risk people's health and safety may not be properly protected. These issues meant the registered provider was not meeting the requirements of the law regarding the safe operation of the premises and assessing and planning care for people. You can see what action we told the registered provider to take at the back of the full version of the report.

People we spoke with, and their relatives, told us they were able to raise any issues or concerns. They said action would be taken by the staff and registered provider to address them. Comments from people who used the service included, "I would talk to the staff if I had a complaint" and "The nurses sort things out, I speak to them when I'm upset about things."

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection three people who used the service had their freedom restricted. Records we checked demonstrated the registered provider had acted in accordance with the MCA.

A thorough recruitment and selection process was in place, which ensured staff employed were suitable to work with people who used the service. Staff told us, and rotas showed, there was consistently enough staff on duty to keep people safe. Staff generally had access to training relevant to their roles; further training courses were arranged following the inspection.

Staff had developed positive relationships with people and treated them with respect and kindness.

People were involved in determining the kind of support they needed. Staff offered people choices, for example, how they spent their day and what they wanted to eat; these choices were respected. People were observed carrying on with their usual routines, going to community day services, shopping and accessing places of interest in the community.

People who used the service and their relatives told us the service was a safe place to live. Staff understood the various types of abuse that could occur and knew who to report any concerns to. There were appropriate arrangements in place to ensure people's medicines were obtained, stored and administered safely.

There was a programme in place to monitor the quality of the service provided to people. We found some areas of this could be improved to make sure any shortfalls in care or services were picked up quickly and addressed. The registered manager's presence at the service and their management oversight would benefit from review to ensure the clinical lead was properly supported and understood the responsibilities of their role.

# Summary of findings

## 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 were not always properly protected from risks associated with the operation of the premises in relation to management of Legionella and aspects of fire safety.

There were sufficient staff to meet people's assessed needs. Recruitment checks were carried out to ensure only appropriate staff worked with vulnerable people.

Staff understood their responsibilities for protecting people from abuse and knew how to respond to any concerns appropriately. People received their medicines on time and as prescribed.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Consideration could be given to the style of fixtures and fittings in areas of the service to provide a more homely environment.

Staff generally had access to training relevant to their roles; further training courses were arranged following the inspection.

People were supported to make decisions and systems were in place to ensure people who lacked capacity were protected under the Mental Capacity Act 2005. The service was meeting the requirements of the Deprivation of Liberty Safeguards.

People were supported to plan, shop and cook healthy meals.

**Is the service caring?**

Good

The service was caring.

People were encouraged to make their views known about their care, treatment and support, and these were respected.

Staff had developed positive caring relationships with people who used the service.

People and their relatives were positive about the care and support given and confirmed privacy and dignity was respected.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Not every person had up to date care plans which would guide staff in how to care for them in ways they preferred and meet their needs.

# Summary of findings

People felt able to complain in the knowledge any concerns would be addressed.

People were supported to participate in a range of social activities within the service and the local community which promoted their social inclusion.

**Is the service well-led?**

The service was not always well led.

The staff at the service completed a series of checks and audits but these had not been fully effective in picking up shortfalls in some safety systems and records.

Staff told us they felt they received a good level of support and direction from the clinical lead. Staff were happy working for the service and were listened to.

**Requires Improvement**

# Bradley Apartments

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

This inspection took place on 28 January and 2 February 2015 and was unannounced.

The inspection was led by an adult social care inspector who was accompanied by a specialist professional advisor who had experience of working with people with learning disability and/or mental health problems.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

We spoke with the local safeguarding team and service commissioners. We contacted two relatives after the inspection.

During the inspection we observed how staff interacted with people who used the service. We spoke with four people who used the service. We spoke with the registered manager, the area manager, clinical lead, two nurses and three care workers.

We looked at the four care files which belonged to the people who used the service. We also looked at other important documentation such as four medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documents relating to the management and running of the service. These included three staff recruitment files, the training record, the staff rotas, minutes of meetings with staff, quality assurance audits and maintenance of equipment records. We completed a tour of the premises.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe living at the service. One person said, "I feel safe because staff look after us all." Another person said, "It's a safe place, staff help us to keep safe."

Relatives we spoke with told us they were happy with the support their family member received and believed it was a safe environment. They also told us there were enough staff to meet people's needs. One person told us, "As a family we are so relieved (Name) is here and safe." They added, "They always have enough staff on."

We saw that an external company had carried out a Legionella risk assessment in October 2014 and water sampling tests were completed, however routine tasks which are a high priority had not been actioned at the time of the inspection. There was no evidence that staff were carrying out regular flushing of showers and outlets not regularly used. Nor was there evidence that shower heads were cleaned and descaled. Legionella is a bacteria which can accumulate rapidly in hot water systems if control mechanisms are not in place. Given the service had opened in recent months and occupancy was low, there were a significant amount of hot water outlets which had not been used, or used on a sporadic basis. The poor management of this meant there was an increased risk to people.

Records showed all staff had completed fire safety training on induction. We found each person who used the service had a personal emergency evacuation plan in case of a fire emergency. Staff prepared for fire emergencies by participating in fire drills; during the inspection a newly employed care worker on their second shift, confirmed they had not been shown the fire safety procedures at the service such as the location of fire exits and fire safety equipment. We also found one of the nursing staff could not locate the key to the fire escape. Although this is opened automatically in the event of a fire, staff should be able to open the fire escape door manually. We saw throughout the main areas of the service that portable fire extinguishers had been moved from their original placement; these were now stored in cupboards and signage indicated this. However, these changes in fire safety precautions had not been updated on the service fire risk assessment.

These concerns about the management of safety at the service meant people who used the service were not properly protected from risks associated with the lack of proper operation of the premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the registered provider to take can be found at the back of this report.

There was a system in place for ensuring equipment was serviced. We checked a selection of records and saw equipment such as the fire alarm, nurse call systems, portable electrical appliances and gas appliances were serviced regularly. Maintenance staff kept a folder of the checks they completed on hot water at outlets accessible to people to ensure they remained at a safe temperature, and window restrictors to ensure they were working properly. These checks enabled staff to identify issues that required attention and helped to maintain people's safety

On the day of the inspection we saw there were sufficient numbers of staff on duty to support people. The clinical lead told us the service was fully staffed and people were supported according to their needs. Some people were funded for one to one support in the service and this increased to two to one when in the community. The clinical lead explained how they worked the hours out to ensure the shifts were covered and extra staff were provided to support activities, trips into the community, and if people were unwell and required increased support. Checks on the rotas confirmed this. Staff absence due to sickness and holiday was covered by the staff were possible, although agency staff were used when necessary. The clinical lead confirmed they employed the same agency staff who knew the people who used the service and this gave continuity of care. We saw the clinical lead had dedicated administration hours. This meant they were able to carry out their management duties effectively. It also meant they were available to cover shifts in case of an unexpected emergency.

Staff recruitment files showed that full checks were carried out prior to their employment in the service. This helped to ensure only suitable staff were employed to care for vulnerable people. Staff we spoke with confirmed they started working at the service only after their police checks had been received and were satisfactory.

Staff told us they had received safeguarding training on induction and the records confirmed this. The clinical lead

Requires Improvement

# Is the service safe?

confirmed they were arranging further courses with the local authority. The registered provider's safeguarding adults and whistle blowing policies and procedures informed staff of their responsibilities to ensure people were protected from harm. Staff had a good understanding of the procedures to follow if a person who used the service raised issues of concern or if they witnessed or had an allegation of abuse reported to them. They told us they felt confident in reporting any concerns to their line manager, registered manager and senior managers within the organisation. They also understood they could escalate concerns to external agencies if required, and considered they would be supported appropriately. Where safeguarding concerns had been raised, we found the clinical lead had taken appropriate action to liaise with the local authority and relevant placing authority to ensure the safety and welfare of the people involved.

Staff confirmed they had attended training to recognise what could cause people's behaviour to change and techniques to use to manage these behaviours. Risk assessments were in place where restrictive practices were used to keep people safe. Records showed that appropriate decisions were made about how and when restraint was used and these were regularly reviewed. Staff told us they tried to use techniques that diverted people's attention, without having any physical contact. This meant staff used the least restrictive practice to protect people's safety. We looked at restraint records which showed how staff had recorded the behaviour leading up to the incident, the holds used, the duration of the holds and the members of staff involved. We found some of the records in December 2014 did not include a debrief for the staff and the person involved; this meant the benefits of review, lessons learnt and support needed may be missed. The clinical lead confirmed they had identified this issue and was addressing this. The more recent records, including those for the day prior to the inspection visit, showed they were all complete and included detailed records of debrief.

We looked at the arrangements in place for the administration of medicines and found these to be safe. Medication was stored securely in a locked cupboard within the clinic room. There was a controlled drugs cupboard and a fridge for medicines that required more specialised storage arrangements. We checked the medication administration records (MARs) for the four people who used the service and found these were recorded accurately. When people were prescribed medicines to take 'when required', there was guidance for staff. The nursing staff administered all medicines in the service. We observed a member of staff administer medicines to people. This was completed safely with checking mechanisms in place to ensure the medicine was given to the correct person. The clinical lead and senior staff completed regular medication audits to check medicines were being obtained, stored, administered and disposed of appropriately. These measures ensured that staff consistently managed medicines in a safe way.

We found there were no self-medication programmes in place for any of the people currently residing at Bradley Apartments. The clinical lead confirmed they were looking to introduce a staged, self- medication programme which meant each person would be assessed to use and be supported with self- medication where possible. This would promote and support a more rehabilitative model of care in respect of people's treatment.

Requires Improvement

# Is the service effective?

## Our findings

People told us they chose their own meals and used healthy eating information and support from staff to do so. One person showed us how they planned their weekly menus with the staff. They said, "We write a shopping list and then go and buy it. I like helping to make the meals." Other comments about the meals included," The meals are nice", "My favourite meal is garlic chicken" and "We decide what we want to eat. I invited (Name) to my apartment for tea tonight, we had fish fingers."

People told us they had access to their GP and other health professionals when required. Comments included, "I went to see my doctor when I had a sore on my leg, the staff arranged this", "My social worker sometimes comes to see me" and "I see the doctor about my anxiety and behaviour."

Relatives we spoke with confirmed their satisfaction with their family member's access to healthcare support and treatment. One relative said, "(Name) was admitted to hospital recently for his seizures, staff had sorted this out quickly and let me know straight away; they are really good like that." Relatives also told us about the recent improvements with healthy eating programmes and how staff were involving them. One person said, "They are getting there and making some real improvements to his diet, some of the staff need a bit more support with this still."

The facilities had once been part of the hospital service and we found they had maintained some of the features of a more secure environment. For example, the TV's in the lounge areas in each apartment were encased in protection cabinets, the style of furniture such as sofas was very robust and observation windows in bedroom doors remained in place (although not used.) We also found on the first day, staff were using two way radios to communicate with each other. The continual use of the radios throughout the service seemed very intrusive for such routine communication and not conducive to the residential and re-enablement model of care detailed in the registered provider's statement of purpose. We found this had been reviewed by the second day of the inspection and radios were no longer in use for care workers.

We found people's rooms were very personalised where they preferred; the majority contained computers, music centres, TVs and they had been decorated with pictures, photos and posters. In one apartment we found the main bathroom had recently been adapted to a wet room to accommodate the person's physical needs.

All new staff completed a two week induction programme at one of the registered provider's other services and a period of shadowing more experienced staff prior to working alone. They told us they had felt confident and competent to start supporting people when the induction period was completed.

The staff training record indicated most staff had completed training considered to be essential by the registered provider. This included safeguarding, moving and handling, health and safety, fire safety, first aid, infection control and basic food hygiene. Further training in areas specific to the needs of the people who used the service was provided. For example: training in communication, mental health awareness, autism awareness, swallowing problems and the management of behaviours which challenged the service. However, training records showed nearly 50% of staff had not completed epilepsy training although one of the people who used the service had complex needs around this condition. The clinical lead confirmed new staff had been recruited since the training was carried out and arranged further courses for the remainder of the staff during the inspection. One qualified member of staff's training in the management of behaviours which challenged the service had expired recently. Following the inspection visit we received confirmation the refresher training course had been arranged.

Records showed most staff received regular supervision with their line manager. They said the meetings gave them the opportunity to discuss the support they needed, guidance about their work and to discuss their training needs. The clinical lead confirmed the staff appraisal programme would commence later in the year.

The Care Quality Commission (CQC) is required by law to monitor the use of the Deprivation of Liberty Safeguards (DoLS). This is legislation that protects people who are not able to consent to care and support and ensures that people are not unlawfully restricted of their freedom or liberty. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control.

Requires Improvement

# Is the service effective?

The clinical lead had made DoLS applications which had been authorised by the supervisory body for three of the people who used the service. We found the authorisation records were in order, they were reflected in the person's care plans and least restrictive practice was being followed. We were unable to see records that confirmed staff had completed training in the Mental Capacity Act 2005 (MCA) and DoLS. The majority of staff told us they had completed this training in their previous work place and they demonstrated a good understanding. The clinical lead confirmed courses had been arranged for qualified staff and this training would be rolled out to all the care staff.

Records showed when people were assessed as lacking the capacity to consent to treatment or to make their own decisions about important matters, best interest meetings were held; we saw decisions were generally made with the involvement of family and other health professionals. Staff were clear about how they gained consent when carrying out care tasks. We observed this during the inspection visit. One member of staff said, "We always ask people about their care. This includes when they get up, personal care support, what they want to eat and how they want to spend their time. Some people have more structured timetables and some people need more encouragement with a healthy lifestyle, but they have choices." One relative told us they were impressed when they overheard a member of staff ask their relation if they could look in their room for a missing item and told us, "They checked this out first; I know it was something quite minor, but it shows their approach with residents."

We saw people choosing what they wanted to eat at lunch time and being supported by staff to prepare their choice of meal. The timing of the meal was chosen by people themselves and they ate where they felt most comfortable.

People had free access to hot and cold drinks whenever they wished. They were weighed monthly and the weight records identified any new risks. The records showed some people had put on weight since their admission. Staff told us they were encouraging healthy meal and snack options where possible. One member of staff told us, "The meal planning has improved recently and we are being more consistent with healthy menu options." We were told that one person's recent weight gain was due to the amount of bread they were eating and staff were now locking this away in a cupboard. Discussions we had with the person who used the service did not identify concerns with this arrangement, however we found this decision had not been recorded in the person's file, which the clinical lead confirmed they would address.

Care records showed that when people became unwell staff arranged for them to see their doctor. We saw evidence that staff sought advice and support from a range of external professionals such as dentists, dieticians, a psychiatrist and specialist nurses with the community learning disability team (CTLD), to support people with their health care. Records showed how staff had recently accessed support from the 'Intensive Support Team' who worked with the CTLD, to help manage one person's behaviours. We found advice and guidance had been incorporated into the person's care plan and staff training sessions with this team had been arranged to ensure the management of this person's behaviour was consistent. Regular monthly meetings were held with the psychiatrist employed by the registered provider to review people's needs and make changes to care interventions and treatment. This meant people's health needs were monitored and their changing needs responded to.

Good

# Is the service caring?

## Our findings

People told us they liked living at the service and staff respected their privacy and dignity. One person said, "I like the staff they look after me properly, they are friendly and kind." Another person said, "My apartment is nice and I like being here, but I would like to share with someone." Other comments were made such as: "I can do lots for myself, but if I need help I ask staff", "Staff knock on the door before they come in", "Staff are good to me" and "Staff are nice and look after me if I get upset and things."

Relatives told us staff were kind and caring. Their comments included, "Very kind approach from all the staff" and "The staff are a really friendly lot, I think that's helped with my son settling here so well."

Relatives also told us they felt able to visit whenever they wished to and were welcomed by staff when they arrived. One person described how supportive staff were to all the family, they told us, "Staff are great, there have been times when (Name) hasn't been in a good mood with me, when we have been in the apartment and the staff have invited me to have a drink in the office with them and a chat about things. It's really nice they pick up on that and are interested in the family as well." They added, "The staff team do seem highly motivated and are very supportive."

We saw people's privacy and dignity was respected. People chose whether they wanted to be in communal areas or have time alone in their room and these decisions were respected by staff. We saw there was a room available on the ground floor if people wanted private conversations or time with visitors in an area other than their bedroom. We observed staff knocked on people's bedroom doors and waited to be invited in. People showed us they could lock their bedroom doors when they wanted to further preserve their privacy. We saw all staff and the clinical lead treated people in a respectful way.

Assessments, carried out before people who used the service moved in to Bradley Apartments, showed that the person, their relatives and other relevant professionals were involved in the planning of people's care. Entries in the care files showed that people's needs were kept under review and reflected that they and those that mattered to them, had a say in how their care was provided. Relatives we spoke with told us staff communicated well with them and supported them to maintain a strong relationship with their family member. One person said, "Excellent communication with the home, the staff phone me each week with a progress report. We've also had a review meeting and we are so pleased with how things are going, we feel really involved."

We found a core group of staff had worked at the service since it opened and knew the needs of the people well. There were also examples of staff who had been recruited from services where people who used the service had moved from. This continuity of staff had led to people developing, and continuing, meaningful relationships with them. Qualified staff we spoke with had an extensive knowledge about people's backgrounds, current family contact and support, personality, interests, their aspirations, how they communicated and expressed themselves, their strengths and qualities and the areas they needed support with. Care workers we spoke with were developing this knowledge base and understanding to support the person centred approach to their care. Staff spoke about people in a compassionate way that demonstrated empathy for the person and their difficulties.

During our inspection, we observed staff and people who used the service interacting together. We found the atmosphere was calm and friendly and there were relaxed conversations and interactions taking place. We saw staff were gentle and unhurried in their approach. People were given time to process information and communicate their response. Where people became excited, upset or anxious we observed staff provided positive support and direction to calm them.

The clinical lead confirmed that a resident's meeting had been arranged for the following week, we saw this was advertised on the notice board. They explained this was the first formal meeting due to the occupancy levels. One person told us they were looking forward to the meeting and wanted to talk about group outings. We saw people who used the service had been provided with a resident's handbook. This gave a range of information such as: how to keep safe, how to make a complaint and how to access advocacy services.

Requires Improvement

# Is the service responsive?

## Our findings

People told us they were involved in planning and reviewing the support they received. They knew about their support plans and had signed them to show they consented to the care and support they received. One person said, "Yes, I've read my care plan, it's all about the help I need. Staff go through it with me." Another person told us they were able to talk to staff about their care plan and commented, "Staff have read this with me and I can ask them questions." They also told us they knew how to make a complaint. They said, "I would talk to the staff if I had a complaint" and "The nurses sort things out, I speak to them when I'm upset about things."

People gave us a lot of examples of how they were supported to access activities of their choice and visits to the local community. Comments included, "When I'm here, I like using my tablet (computer device) and listening to music", "I go out a lot, I go to discos, do the shopping, go to the cinema, watch Grimsby Town play, go bowling and out for meals", "I like going to Foresight (community support organisation), we do good things there", "I like going for a walk and staff come with me and sometimes we go to shops" and "I'm going fishing soon, (staff member) said he would take me."

People's family members considered their relatives received a good standard of care and had good opportunities to participate in social activities within the service and in the local community. One person said their family member was getting out into the community much more by being involved in shopping trips and outings to cafes. They also commented that staff supported their family member to celebrate public holidays and events by involving them with themed meals, dressing up and decoration of the lounge. They said, "(Name) had a great time at Halloween, absolutely loved dressing up." Another person's relative described what peace of mind they had since their family member had moved to the service. They explained how staff clearly understood the positive behaviour strategies put in place and how they were all consistent in their approach and the positive outcome this was having. They said, "(Name) has come from a place where there were few boundaries and staff weren't confident in keeping a check on things like behaviours, healthy eating and routines; but it's so different here, much more structured and everything is monitored much more closely. It's working so well. I have weekly telephone calls for updates."

Despite the positive comments from people who used the service and their relatives about the quality of care support and activities we found the quality of the care records was inconsistent. The care files we looked at contained assessments, risk assessments and plans of care. However, we found there were no risk assessments in place to support one person's changing health needs. For example, they used a wheelchair and required supervision when mobilising yet there was no moving and handling risk assessment to identify the current risk and care support. Similarly, the person had experienced three falls since they had been admitted but there was no falls risk assessment in place. Given the complexity of this person's health needs and reluctance to move position, we also found the risk of the person sustaining pressure damage had not been assessed.

The care files for two of the people we looked at contained detailed risk assessments and plans of care to meet all their needs. These care records contained individual goals to achieve and had been reviewed regularly. The information was well maintained, in order and easily accessible. The remaining two care files we looked at were not so well developed or maintained; the care had not been sufficiently planned or reviewed. For example, the behaviour support plan to encourage a person with a positive sleep pattern was poor. There was some guidance about switching off the TV at a certain time and disengaging to encourage going to bed, however there had been numerous incidents where the person was reluctant to retire at this time and had become angry and aggressive, but there was no clear plan to direct staff on a consistent approach. We were informed that the person had recently been provided with a TV in their room to encourage more rest but this strategy was not detailed in the records.

Similarlarly, the support to meet the person's personal care was not clearly documented and some of the records were contradictory. One record limited the person's access to the lounge area if they had not attended to their personal care within a certain time frame, although the nurse on duty confirmed this was not being followed and was recorded in error. A reward programme to improve personal care

Requires Improvement

# Is the service responsive?

routines was in place, but during the inspection we saw the wrong day was detailed on the programme board in the lounge, which meant staff were not supporting the person to engage in the programme.

These shortfalls in assessing and care planning people's needs meant there was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the registered provider to take can be found at the back of this report.

Care files for two of the people who used the service had Health Action Plans (HAPs) in place which detailed how they were being supported to manage and maintain their health. They also had communication passports which contained information about the person's health and how they communicated their needs and wishes. These records would provide appropriate information if the person was transferred to another service or admitted to hospital. The clinical lead confirmed they would ensure all people who used the service had these records.

We found staff maintained detailed records to support the care provided each day. On some occasions we found staff had used language which was not appropriate such as describing someone's behaviour as 'silly' or 'naughty.' The area manager confirmed these concerns would be followed up and addressed.

During the visit we saw people were supported with a range of activities such as visiting the cinema with relatives, going to a disco, shopping trips and attending a community placement. One person had their own activity plan which included household, work/education and leisure pursuits. The plan had been provided in pictorial format on a large board; however staff were waiting for the maintenance team to put it up in the person's apartment. The person described the types of jobs they enjoyed such as cleaning the service vehicles and assisting with some of the routine maintenance work. They also described how they tried to be independent and enjoyed assisting with laundry, cooking and cleaning their apartment. They said, "I peeled the potatoes for three people yesterday, I like doing jobs."

Other people in the service had activity programmes in place or these were being developed. We saw one person participated in regular activities and courses provided by a community organisation. They told us they enjoyed doing these. Staff from the service accompanied the person to these day services and supported them at the sessions.

We found one person was using the gym facilities at the adjoining hospital service and we spoke with the clinical lead about arranging support for the person to attend a gym in the local community. Similarly with accessing personal monies, this was also done via the administration department at the hospital facility and personal bank accounts in the community had not been arranged, which would support a more a more independent model of care.

Relatives and people who used the service told us they felt comfortable approaching staff and the management team with issues or concerns. One person's relative said, "I did have some concerns and spoke with the staff. They listened to what I had to say and sorted things out." Records showed that no formal complaints had been received about the service.

Requires Improvement

# Is the service well-led?

## Our findings

We asked people who used the service and their relatives about the management of the service. Each person spoke about the clinical lead and all comments were positive. People were not aware of the registered manager. Comments from people and their families included: "(Name) he is a nice guy, he's here most days and sometimes he comes to see me" and "We have a lot of confidence in (Name). He is very approachable and runs the home very well."

The registered manager was also the registered manager of the low secure hospital service which shares the same site. They were appointed to manage the hospital whilst Bradley Apartments was being developed and set up; their registration for this service was completed when it opened in May 2014. We spoke with the registered manager during the inspection. They explained how the clinical lead had day to day management responsibilities for Bradley Apartments which they oversaw. However, during discussions with the registered manager it was not clear what formal arrangements were in place to oversee the general management of the service and they demonstrated a limited knowledge about some current aspects of the service. There were no records of any formal meetings between the registered manager and the clinical lead, however the clinical lead described the registered manager as very supportive and confirmed they regularly met to discuss the service.

Staff described the clinical lead as 'a very good manager' and 'very approachable.' Staff also described the area manager as very supportive. Staff did not describe much involvement from the registered manager with the day to day running of the service. One member of staff said the registered manager; "Popped in from time to time" and another considered the registered manager was more visible if the clinical lead was away from the service. Following the inspection visit we were informed that a meeting between the clinical lead, the registered manager and the area manager had been scheduled to look at improving some of the management and administration systems in place and defining some of the day to day managerial responsibilities.

Staff told us morale was good and they were kept informed about matters that affected the service. Staff were positive about their role and how the service was developing. We observed the staff team got on well together and interacted well with each other to ensure consistent and co-ordinated care. Regular staff meetings were undertaken and recorded; we saw the records for a recent meeting which covered topics such as practicalities around cleaning duties, the new healthy eating programme, as well as discussions regarding individuals and any concerns or ideas in respect of their support. Staff told us the meetings were an opportunity to raise new ideas. They told us they believed their opinions were listened to and ideas and suggestions taken into account when planning people's care and support.

The clinical lead described the systems in place to consult with people on the running of the service. So far, the main processes involved feedback about the service through formal meetings, such as individual service reviews with relatives and other professional's. A resident's meeting was arranged for the following week. Surveys had been issued to staff which showed positive results. The remainder of the survey programme was scheduled to be rolled out later in the year, when surveys would be issued to people who used the service, relatives and stakeholders.

There were systems in place to assess and monitor aspects of the quality of the service provided. We saw audits were carried out for areas such as: health care records, medicines, security and safety, incidents and accidents, and records and documents. A recent care file audit in November 2014 had identified shortfalls but there were few action points developed to address these. The audit checked for whether documentation was in place but there was little evidence the quality of the care plans was assessed. The shortfalls we found in the quality of risk assessments and care plans should have been identified in care file audits. Similarly other shortfalls we found such as staff training and management of the risk of legionella could have been identified earlier through audit. The clinical lead confirmed that they had recognised some of the audit tools were limited in scope and we were shown how they had obtained more detailed and comprehensive records which would be implemented in the near future.

Incidents and accidents were monitored at service level but this information was not yet included in the registered provider's clinical governance programme, which the area manager confirmed would be addressed. The clinical lead represented the service at the joint health and safety meetings held on the site.

Requires Improvement

# Is the service well-led?

We sampled a range of key policies and procedures such as medicines, safeguarding vulnerable adults, use of restraint/ physical interventions, health/ safety and infection control. We found some required review to reflect current practices at Bradley Apartments. We discussed this with the clinical lead who confirmed a member of the clinical staff was currently involved in project work to review the policies and procedures with other services for the registered provider.

We found there were some staff incentives at the service such as long service awards and pay enhancements when staff completed nationally recognised training qualifications. The clinical lead was clear about the values and ethos of the service which he felt would be more embedded as the service developed and established a clearer identity separate from the adjoining hospital service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>How the regulation was not being met: People who use services were not protected against the risks of receiving care that is inappropriate or unsafe. This was because assessments of people's needs and planning of care to meet those needs had not been carried out consistently for every person who used the service. Regulation 9 (1) (a) (b) (i) (ii). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br><br>How the regulation was not being met: People who use services were not properly protected from risks associated with the lack of proper operation of the premises in relation to management of Legionella and aspects of fire safety. Regulation 15 (1) (i) |