Aitch Care Homes (London) Limited

Coneyhurst Lodge

Inspection report

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West Sussex
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Website: www.regard.co.uk

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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

Coneyhurst Lodge provides accommodation and personal care for up to ten people with a learning disability, people on the autistic spectrum and people with physical disabilities. At the time of our visit six people were living at the service and one person was receiving short term care. It is situated in a residential area of Worthing, West Sussex. People had their own room's which all had en-suites. Communal areas included a lounge, dining room and a small sensory room. Outside space included a garden area with a large trampoline and an additional garden sensory room.

The service had a registered manager who had been recently registered in December 2016. 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.

At the last inspection on the 12 and 13 April 2016 we identified one breach of Regulations associated with personalised care. A recommendation was also made in relation to staff using consistent caring and compassionate approaches. Following the last inspection, the provider wrote to us to confirm that they had addressed these issues. At this visit, we found that the actions had been completed and the provider had now met the legal requirement.

At the last inspection, we identified people's care and treatment did not consistently reflect their needs or preferences and care records were not regularly reviewed. This was in breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made. Care plans had been developed and reviewed within the past month, they considered each person's preferences and the support they required from the staff team to meet their needs. Care plans included how to support people positively to reduce their anxieties and manage behaviours which may challenge others; therefore this regulation was now met.

At the last inspection, we observed a lack of support provided by staff on duty for one person who seemed agitated. At this inspection, we found staff used a kind and compassionate approach involving people in choices about all aspects of their care including how they wanted to spend their day.

Prior to this inspection, the local authority shared their concerns with the Commission about the care and support being provided to people, particularly around managing behaviours which challenged. This included numerous safeguarding concerns regarding physical assaults by people who no longer lived at the home and how this was managed. The provider had notified us about incidents involving physical aggression between people and other notifiable events. Relatives and staff told us the home had not been a safe place for people to live. At this inspection systems had been put in place to consider the safety of those living in the home. However, further time and work was needed to ensure the systems were embedded in practice and sustained so that the safety of people is consistently protected in the future.

The provider had recently sent out satisfaction surveys to relatives to gain their views on the care provided. Most relatives told us about the difficulties they had experienced regarding poor communication with the home and had lost confidence with the provider and the support provided to their family members. We shared this feedback with the provider as this area required further improvement. The provider told us the action they would take which included inviting relatives to meet with them to discuss past experiences and recent changes in the home.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk from harm. People were treated with dignity and respect. Staff knocked on people's doors before entering to promote privacy. Staff attended training provided and understood their role and responsibilities.

Risks to people had been identified and assessed and information was provided to staff on how to care for people safely and mitigate any risks. There were sufficient knowledgeable staff on duty to meet the needs of people and medicines were managed safely.

We found the home clean and tidy and people's bedrooms were personalised with their own belongings such as photographs of family members or items of interest. The home had undergone a decoration programme which included new carpets. There was a maintenance plan in place which highlighted the areas of the home which remained in need of decorating which included the lounge.

People were offered enough food and drink and were given a choice of what and where they ate their meals. Staff responded to changes in people's health needs and their support was reviewed when required. If people required input from other health and social care professionals, this was arranged.

People were offered activities to attend in and outside of the home. Complaints were treated seriously and were overseen by the registered manager and the locality manager. People were provided opportunities to give their views about the care they received from the service, this included activity and menu planning meetings.

There was a range of audit processes to measure the overall quality of the service provided to people and to make improvements.

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.

Further work and time was needed to ensure people's safety was consistently protected in the future.

Staff were trained to recognise the signs of potential abuse and knew what action to take.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were sufficient numbers of staff and the service followed safe recruitment practices.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People's care needs were managed effectively by a knowledgeable staff team that were able to meet people's individual needs.

Staff received regular supervision and appraisals. Training was provided and refresher courses were booked.

People had enough food and drink and received support from staff when required.

Staff understood how consent to care should be considered.

People had access to health care professionals to support maintaining good health.

Is the service caring?

Good

The service was caring.

People were supported by kind, friendly and respectful staff.

People's well-being was taken into consideration in the approach used by the staff team.

People were able to express their views and be actively involved in making decisions about their care.

People's privacy and dignity was respected and people were supported to exercise choice in how they spent their time.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff.

Care plans were individual to the person being written about.

People were offered activities within the home and the community.

Concerns and complaints were listened to and action was taken.

Is the service well-led?

Requires Improvement

The service was not always Well-Led.

The culture of communication between the home and people's relatives was not always open, positive and consistent.

Staff spoke positively about how the service was managed and understood their role and responsibilities.

A range of quality audit processes were in place to measure the overall quality of the service provided.

Coneyhurst Lodge

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 1and 2 February 2017 and was unannounced. The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by experience at this inspection had experience of services for people with a learning disability.

Prior to this inspection we reviewed information we held about the service including previous inspection reports and information from the local authority. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we observed care provided by staff to people including how medicines were administered to people and the lunchtime experience. We met with six people living at the service. Due to the nature of people's complex needs, we were not always able to ask direct questions. However, we did chat with people and observed them as they engaged with their day-to-day tasks and activities. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We also spoke with five relatives by telephone to gain their views of the care provided to their family members. A physiotherapist who visited the home also shared their views on support provided to one person living at the home.

We observed a handover meeting where information was shared from morning staff to the afternoon staff. We spoke separately with a senior support worker and two support workers. The registered manager was facilitating training in another service during our inspection however made time to introduce themselves and we spoke separately with them by telephone shortly after the inspection. The locality manager, an additional manager and the deputy manager, who were supporting the home at the time of our inspection,

made themselves available throughout our inspection.

We spent time looking at records including three care records, three staff files and staff training records. We also looked at staff rotas, medication administration records (MAR), health and safety maintenance checks, compliments and complaints, accidents and incidents and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At this inspection we found people were relaxed and looked happy in the company of the staff supporting them and other people they lived with. Some relatives told us the home had not been a safe place for people to live. This was due to the numerous physical assaults that had taken place between people. Prior to the inspection the local authority also shared their concerns regarding the level of incidents reported and how this was being managed by the provider. The locality manager explained how they continued to investigate one concern regarding staff conduct. The staff member was not currently working at the home. During this difficult period the provider had taken action to minimise the risks to people living at the home. This included increasing staffing levels and supporting the registered manager to become a trainer in how to prevent and manage behaviours which may challenge so he could train and mentor staff accordingly. Support was also given by the providers positive behaviour support team who reviewed the needs of people who may challenge others.

At this inspection there were six people living at the home and another person staying alternate weekends. Some people had recently moved out into other services, as recent as December 2016 after being served notice by the provider. This had directly impacted the safety of people living at the home as there were no longer incidents of physical assaults between people living at the home. The last physical assault incident was reported to the Commission and the West Sussex safeguarding team on the 11 November 2016.

Staff were now able to support and engage with the remaining people living at the home without the constant distractions of behaviours which the home had found difficult to manage. Staff told us these recent changes had improved the quality of care they were able to provide to the people who remained living at the home and how communal rooms within the home were used. One relative said, "I feel [named person] is safe now, although new residents are moving in. The change is just since Christmas". Another relative told us, "I never thought [named person] was badly treated by staff, they seem generally good and friendly with [named person]". The registered manager and locality manager told us how they intended to assess each person before they moved into the home in the future as compatible with the existing group of people already living there. The registered manager said the, "Compatibility of service users" was of "Utmost importance". They added, "People were now feeling safer in their own home". A staff member told us, "All people are more relaxed now". At this inspection systems had been put in place to consider the safety of those living in the home. This included intensive training for staff on how to engage with people who may challenge and consideration to how people moving into the home are assessed. However, further time and work was needed to ensure the new systems were embedded in practice and sustained. The Commission will inspect the home within 12 months after the published date of this report to check that the safety of people living at the home is consistently protected in the future.

Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the deputy manager, registered manager or the locality manager in the first instance and failing that would refer to the whistleblowing policy for advice and guidance.

Care records contained risk assessments. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. We found risks were managed safely for people and reviewed every six months or sooner if required. At the time of our inspection, updates in risks assessments were in the process of being read by the staff team as they had recently been reviewed in January 2017. They covered areas such as how to reduce risks to people who experienced epileptic seizures, when supporting people accessing the community and the steps to take to support people with eating and drinking. They also included guidance on how to reduce risks for people who may challenge others including people they live with. Staff told us they found the guidance helpful and thorough. Risk assessments were specific to individual needs, updated and reviewed every six months or sooner if required and captured any changes. For example, during our inspection we observed an incident whereby a person pulled on a staff member's hair. As this was now a highlighted risk a new risk assessment was promptly put in place to ensure the risks to the person and the staff supporting them were reduced. This included staff with long hair tying it back out of reach. A senior support worker told us, "If you see a staff member not following a risk assessment, we hold a professional discussion straight away".

Most risk assessments we read were current and meaningful. However, one person used a wheelchair and required support from staff to help them to move safely. They had a risk assessment in place which provided guidance for staff on how to support the same person to stand using a standing aid. There were no records in place made by staff in the persons daily records to state when this had happened and staff we spoke with seemed unclear about how often it should be offered. Concerns were also raised from a visiting physiotherapist regarding the use and maintenance of the standing aid. The management team took action and added further guidance and training for staff to ensure the person used their standing aid as assessed. Changes to daily records prompted staff to include when the exercise had been offered and taken place to promote consistency in the approach used. The locality manager also responded in full to the concerns raised. We have referred to this in the Well-Led section of the report.

We observed, and rotas confirmed, there was enough staff on duty to meet people's needs safely. On the first day of our inspection, which was unannounced, there were two senior support workers and two support workers and the deputy manager supporting people. Throughout our inspection people communicated their needs and staff responded to them without delay. There were two support workers, one senior support worker and a deputy manager on duty supporting people during our inspection. The rotas confirmed there were between three or four staff on duty during the day supporting people. On occasions, records showed five or six staff on duty however, some staff started at different times, such as a middle shift depending on planned activities people were participating in. Some people had agreed one to one time which was factored in on the rota to meet their assessed needs and we observed this support being delivered. There was also a support worker awake during the night and another on a sleeping duty who could be called upon if needed for additional support. However, most relatives shared previously there had not been enough staff on duty especially at weekends yet some felt this had improved since some people had moved out. One relative told us, "There's not always enough staff on at the weekends. It's ok at the moment because there are less residents". Another relative said, "I am worried I know some of the staff do nights as well as day and when you're tired that's when things get missed and go wrong". We fed back relatives concerns to the locality manager who told us, 'We have done our best at ensuring the right number of trained/skilled staff are on each shift and have previously used agency to ensure that we have been able to do this. We no longer use agency now because we carried out a focused recruitment drive'. The provider will need to review staffing levels as people move into the home to ensure people's needs continue to be met.

Personal emergency evacuation plans were in place. In the event of an emergency, staff knew how to

support people to be evacuated safely. Accidents and incidents were reported appropriately and documents showed the action that had been taken afterwards by the staff team. Records showed that the relevant professionals and had been contacted.

Staff recruitment practices were thorough. Staff were only able to commence employment once all appropriate checks had been carried out including obtaining two satisfactory references checks with previous employers and that staff held a current Disclosure and Barring Service (DBS) check. Recruitment checks helped to ensure that suitable staff were supporting people safely within the home.

Medicines were managed safely. The registered manager had notified the commission of one medicine error in October 2016 and the action they had taken to minimise further risks to people. We found only trained and competent staff were authorised to administer medicines to people. People's medicines were held in a locked facility within a medicine room. They were mainly stored in blister packs which were labelled and corresponded with a clear recording system. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. We observed the deputy manager administering medicines to one person. The Medication Administration Record (MAR) was completed and signed on behalf of the person by the deputy manager after the person was supported to take their medicine. The deputy manager bent down and used a calm and flexible approach when administering medicines to the person. They were able to discuss confidently safe medicine procedures and explain why certain medicines were prescribed to the person. Guidance was also provided for staff when administering 'When required' (PRN) medicines. This included medicines for pain relief or skin conditions.

We checked other people's MARs and their related blister packs and found they were complete with staff signature entries. Medicines were audited weekly by senior staff to ensure any administrative errors were highlighted and managed effectively on behalf of people. Senior staff told us the home was changing to a monitored dosage box system within the next few months. People had also had individual medicine cabinets fitted in their bedrooms with a view to a more personalised process.

Good

Is the service effective?

Our findings

During our inspection we observed care provided to people by staff who were skilled and knowledgeable about the people they were supporting. When we posed questions to them about their approach they were able to respond articulately about why they did things in a certain way. However, we received mixed opinions from relatives as to whether the care provided was effective. This included their frustrations regarding staff and their communication to them when English was not their first language. One relative told us, "The staff are good and polite when we visit and they seem to have good communication with my [named person]". Another relative said, "I think the staff are fairly well trained". A third relative told us, "I think they (staff) do their best but I think there is a lack of training for [named person's] needs". A fourth relative told us, "I think the staff do their best but it's hard as there is a high staff turnover". We fed back the comments to the locality manager. They told us, 'There has been some turn over as you will have seen, I believe that this is because we have been managing colleague performance well and addressing issues so people have moved on of their own accord in some instances and for others we have reached the decision to terminate their employment with us. We have several new colleagues who seem very nice'.

People received support from staff that had been taken through an induction process and attended training which enabled them to carry out their care worker role. The induction consisted of a combination of shadowing shifts and the reading of relevant care records and home policies and procedures. Newer staff were supported by the registered manager and the deputy manager using observations to assess their competency before performing their tasks independently within areas such as providing personal care.

The mandatory training schedule covered topic areas such as safeguarding, first aid and infection control. Some existing staff had completed autism, intensive interaction and challenging behaviour training which was specific to the needs of the people living at the home. Newer staff were awaiting to attend in early 2017. The registered manager accessed face to face sessions, workbook based and on line training for all the staff team and retained evidence of training attended within their staff files. Refresher training was provided to ensure staff routinely updated their knowledge on particular subjects. The registered manager and locality manager were trained to facilitate techniques to staff to enable them prevent and de-escalate incidents which may challenge other people and staff. The provider also had an internal positive behaviour support specialist who had recently supported staff in how to effectively engage with people and the various behaviours they displayed. All staff we spoke with told us they had enough training and knew they could request more from the registered manager if they needed to.

Support was also provided to staff on a one to one basis in supervision's and appraisals and monthly staff meetings. The opportunities were used for staff to reflect on their practice supporting people, discuss any training needs and other issues relating to the work place. Staff received supervision every few months and also had an annual appraisal. The registered manager told us, and records confirmed there were five staff members out of 20 due to have an appraisal. The registered manager told us these were planned to take place within the next two months. They told us as they were receiving support from the locality manager to do this as they were new to the process.

Staff confirmed they had regular supervisions and told us they found these helpful. However, one staff member told us they would prefer to have their supervision meeting directly with the registered manager rather than a senior support worker. This was fed back to the locality manager during our inspection for their review. A senior support worker told us how they found the support offered to staff had improved since they started in June 2016. They told us the environment had become, "A lot more nurturing for staff". They added, "There are a lot more opportunities for staff to put forward ideas". They discussed how this had benefitted people living at the home and that it was a more positive place to work. Another staff member told us, "If I ask for help I get it". A relative told us, "The newer staff seem better trained".

New staff had completed the Care Certificate (Skills for Care). The Care Certificate is a work based achievement aimed at staff who are new to working in the health and social care field. It provides an opportunity for providers to provide knowledge and assess the competencies of their staff. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment. In addition, some staff had completed various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard. The registered manager told us their aim was to, "Make sure staff are well trained"

Consent to care and treatment was sought in line with legislation and guidance. 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 checked that the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, mental capacity assessments had been completed on behalf of all people and staff had received training on both topics. We observed staff gaining consent from people before carrying out a particular task for example, entering their bedroom. The locality manager told us, and care records confirmed that a standard authorisation DoLS application had been made for people who lacked capacity to consent to their care placement. So far, two DoLS had been approved; the process had included people's relatives and the appropriate health and social care professionals. Therefore people's rights had been protected in line with current legislation. At the time of our inspection the home had yet to notify to Commission regarding the two DoLS which had been approved this was completed by the end of our inspection where we received two statutory notifications. The registered manager spoke confidently about MCA and when to complete a DoLS on behalf of a person and when it was not necessary including when a person had capacity to make decisions regarding their own care and treatment.

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs and preferences. People could choose where they ate which was mostly in the dining room however the option of the larger lounge was also used. People were invited to attend weekly meetings which were specifically designed using pictorial images to support people to choose their favourite meals. The meals chosen for a particular day were then displayed on a notice board near the kitchen accessible for all. On the first day of our inspection people had chosen jacket potatoes with various fillings for lunch and the evening meal was a tuna and pasta bake. We observed staff refer to this with people on a regular basis

and engage with people in the kitchen area to promote their involvement and their independence. A staff member was allocated at the beginning of each shift as to their responsibilities with cooking meals. Staff supporting a particular person recorded what they ate and drank throughout the day to ensure diets and hydration was monitored.

Staff told us the kitchen was, up until recently, kept locked and now that it wasn't it meant people living at the home could access the kitchen when they chose to. We observed staff supporting people at all times when they were in the kitchen. This meant risks to people were minimised when being supported with meals and snacks. One relative told us, "I'm not impressed with the food I've seen there isn't one dedicated cook. I've asked for a plan of the menus/meals but they (staff) haven't given me one". We have discussed relative's views more in the Well-Led section of this report.

People had access to healthcare professionals. Where healthcare professionals were involved in people's lives, this care was documented in the care plan. For example, we noted that GP's, psychiatrists and psychologists were involved with some people's care. Healthcare action plans were completed annually. A healthcare action plan is a document that is drawn up about a person, it explains how they can keep healthy and the help they are able to get or are getting. This showed how staff were involved in supporting people with their healthcare appointments. Staff told us they would report to the registered manager if they had any concerns about a person's health. Staff were able to contact health professionals directly if there was a need. However staff also told us they would document any changes and report back to the registered manager to gain advice and guidance. A senior support worker described how they would determine whether a person needed additional support from a health professional and told us they would be informed by how the person presented and whether their mood or behaviour had changed. They also told us they had very good working relations with the local GP and said if needed they came to visit people at the home.

Good

Is the service caring?

Our findings

At the last inspection, we recommended the provider gave further consideration to ensuring that people were consistently treated in a caring and compassionate way. This was due to our own observations and feedback from relatives at the time. However, at this visit we found positive and caring relationships had been developed between people and staff. Staff smiled with people and looked approachable; their interactions were warm and personal. Staff used people's preferred names during conversations and asked their permission before undertaking tasks. One relative told us, "I think the staff are caring, it's a difficult job". Another relative told us, "There are good staff now".

We observed people could move freely around the home assisted and supported by staff to where they wanted to be. This was consistently carried out by staff in a kind manner who offered support yet considered people also needed their own space. Staff enabled people to communicate and express themselves without 'jumping' in too early and taking over. This allowed people to take the lead and direct their own wishes. Staff were heard chatting to people about general matters such as the weather and what had been on television. Staff also covered topics pertinent to the individual such as people's favourite music, updates on people's relatives and what activity was planned. Staff told me one person was presenting behaviours associated with increased anxiety. They told me this was due to people leaving the home to live in other services and other changes within the home. We observed the person required the continuous support from their allocated staff member. Throughout our inspection we saw how various staff members used a flexible approach and provided the necessary support to this person. This helped to diffuse their anxieties and enabled them to engage with more positive activities and distracted them away from what was distressing them. This meant staff had considered people's well-being when providing care. A senior support worker told us, "Staff are so much more proactive now". They felt the support received from the management team including the positive behaviour support specialist had helped the staff team to, "Really gel together".

Staff told us and our observations confirmed how people were supported to express their views and encouraged to be as independent and as involved as much as was possible with their own care and support. This included with their daily household chores such as the cleaning of their own bedrooms. Opportunities were provided for people to attend weekly and monthly group meetings to discuss their meal choices and activities people wanted to attend. People were offered choices about how they wanted to spend their time in and outside of the home. A senior support worker said it was about, "Giving people choices and respecting their choices". They added this was, "Within reason" and shared how they guided people to wear clothes which suited each weather type when they were out in the community.

The locality manager also referred us to reference boxes that had been created for people that found it difficult to express themselves. They were filled with items of importance to the individual person which staff could use to engage with a person more effectively. These were yet to be used by people and staff as they had not been completed. However, it meant the home had considered how improvements could be made to support people to express themselves and aid their ability to communicate their.

People were also allocated one or two keyworkers. A keyworker is a staff member who helps a person

achieve their goals, helps create opportunities such as activities and may advocate on behalf of the person and their care plan. Staff became key workers once they had achieved their basic core training. People were involved in choosing their key worker/s. We asked relatives their views on the keyworker role. One relative told us, "I have very good communication with his key worker". However, another relative told us, [Named person] has a keyworker but we don't have regular contact". We referred to communication with relatives in the Well-Led section of this report.

People were treated fairly and with dignity and respect. Staff were observed knocking on people's bedroom doors and waiting for a response before they entered. Staff talked to people whilst they were supporting them so they gained their consent and people knew what was happening. Staff could advocate on behalf of the people they were supporting, they seemed to know when they were happy or sad and act accordingly to ensure their needs were being met. All staff members we spoke to told us how they would support people to draw their curtains before supporting them with personal care. One staff member told us how they promoted people's dignity and described their caring practice and said, "It's their home and we support them with everything they want".

We noted during our inspection recently updated care records including daily records were kept downstairs in the main lounge in a cupboard which was not locked. Due to the confidential nature of the information we discussed this with the locality manager. By the end of the inspection the same care records had been moved to the office on the first floor which was kept locked. We spoke with the registered manager shortly after our inspection who confirmed this had been an oversight. They explained a lock had been fitted to the same cupboard downstairs. This meant staff could access care records and protect confidential information pertinent to people living at the home.

Good

Is the service responsive?

Our findings

At the inspection in April 2016 we found the provider was in breach of a Regulation associated with personalised care. We had identified care plans did not consistently reflect people's needs and preferences and were not always reviewed. We also found activities for people were planned but did not always take place. Shortly after the inspection the provider sent us a plan of what action they had taken and what improvements they had made. At this inspection records checked and our observations confirmed improvements had been made. The care plans or support plans, as named by the provider, in place had been updated to reflect people's current needs and last reviewed and updated in January 2017. We also observed people taking part in activities which had considered their needs, preferences and choices on the day. Therefore the legal requirement had now been met.

Each person had a care record which included a support plan, risk assessments and other information relevant to the person they had been written about. Support plans were reviewed regularly and included information provided at the point of assessment to present day needs. They provided staff with detailed guidance on how to manage people's needs, their goals and their aspirations. This included guidance on areas such as communication and behaviour needs, community activities and promoting independence. People's preferences were captured within their support plans and they were written in the first person. For example, one support plan we read described the top six things important to them. One of them was, 'Keeping in contact with my family'. The same support plan read, 'I will take you to the kitchen if I am hungry'. Another support plan gave direction to staff on how they should support a person with eating as they were at risk of choking. The same support plan described how the person disliked their hair being brushed and the set language used to reassure the person whilst the care task was being completed.

Positive Behaviour Support (PBS) plans were also in place for people that may display behaviours that challenge. The plans had been developed with the support of the providers positive behaviour support specialist. They contained strategies of how staff should support people to reduce anxieties and manage behaviours displayed. Staff told us how this approach had empowered people and enhanced their quality of life.

The locality manager explained how any changes within care plans were made accessible to staff in the 'read and sign' file. We observed staff reading the latest changes during our inspection.

Daily records were completed about people by staff at the end of their shift. They included information on how a person presented during the day, what kind of mood they were in and any other health monitoring information. Changes to people's needs were highlighted through various methods including reviews and speaking directly to people and their families.

During our inspection we checked to see whether people had activities and stimulation planned on their behalf and what was planned had taken place. The focus on activities was determined by how people wanted to spend their time throughout the week. People attended activity meetings. Pictorial references were used with people to help them to make decisions about what they wanted to do. Records checked

showed a meeting on the 28 January 2017 discussed bowling, cinema, arts and crafts and a walk in the woods. Pictorial activity plans were in place and displayed on the wall in the downstairs hallway. They included structured activities important to each person. Household chores and personal shopping were entered alongside exercise session or more fun events and outings. We asked why they were displayed in the hallway and not in people's rooms. Staff told us they were used as a reference point throughout the day and we later observed this in action. If a person appeared anxious about what was happening next the staff member was able to refer to the activity plan easily and quickly to alleviate any anxieties.

Throughout the inspection we were able to check a person's activity plan and cross reference with what the person was actually talking part in and mostly this matched. When we queried changes it was because one person had not been feeling well and another person had changed their mind and opted for arts and crafts instead of the planned outdoors activity.

All staff told us people were able to attend activities including accessing the community at least once a day sometimes more. They told us how they tried different activities with the person to see if they liked them. One staff member said, "We now have more time to do more activities to support them (people) how they want". We noted only one person attended a local college. The locality manager shared they were looking at building better links with local colleges to offer a more educational environment for some people if it met their needs. A staff member told us they had ideas of how to improve how activities were offered to some people living at the home. We shared this with the locality manager for their review.

The registered manager and staff told us how they involved relatives with the planning of their family member's care. However, we received mixed feedback from relatives as to whether they had been involved with people's support plans and some relatives were unclear about what activities were happening and when. Most relatives felt there should be more activities offered to people and shared frustrations about the lack of communication about the care provided to their family members. One relative said, "[Named person] gets taken swimming but is supposed to be one to one with a key worker for a number of hours per week and I don't know if that happens". Another relative said, "There has been improvement…but there's not enough activities". We have discussed communication with relatives in the Well-led section of the report.

At the time of our inspection there were no official formal complaints open. The home had an accessible complaints procedure and we checked how formal concerns and complaints were responded to. Complaints were responded to promptly and records were maintained regarding any actions taken by the home. The last formal complaint was closed in September 2016.

Requires Improvement

Is the service well-led?

Our findings

During our inspection, we recognised improvements had been made to the approaches used by staff and care records. The management team presented as open in their response to all discussions held.

The registered manager had been managing the home since August 2016 and registered with the Commission in December 2016. Over the previous six months, there had been a lot of changes within the staff team and their practice. Although new systems had been put in place, these were not yet embedded in practice and further time was needed for the registered manager to develop better communication with people, relatives and external professionals and restore trust.

Relatives appreciated improvements had been made and felt the registered manager was caring yet remained disillusioned about the home and what it offered. They shared their frustrations regarding the care their family members had received. This had prompted some relatives to consider alternative accommodation. Their opinions were influenced by incidents of aggression from people who used to live at the home and comments about the lack of communication from the management team. For example, one relative told us they were not informed immediately regarding a medicine error which had occurred. One relative told us, "I don't think the home is a happy home really…there is a lack of communication and time". Another relative said, "I don't think it's well-led, there are lots of good things about it, the carers are kind and good with [named person] but no it's not well run". A third relative said, "The home is getting better at communicating but no one knows what anyone else is doing. Sometimes if I call to speak to someone about things I feel I am being put off…they don't return my calls. It's chaotic".

The registered manager told us they were in the process of sharing the revised care records with all relatives to involve them in the care planning process. They said they valued the input from relatives as people couldn't always express their views and preferences. They had also recently sent satisfaction surveys to relatives to gain their views on the care provided to their family member's views. However, due to the feedback we received from relatives and a visiting physiotherapist we identified consistent and effective communication with others involved in people's care required improvement. During our inspection the management team promoted a positive and open culture however this needed to be extended to all relatives who were involved in people's best interests and decisions surrounding their care and treatment.

We fed back the comments to the management team. The registered manager told us they were not surprised by some of the negative feedback however felt, "The service is a better place now". They explained how they had improved the induction and training programme for new staff and they had the, "Right compatibility" of people living in the home. They added, "It's a completely different service now". The locality manager told us they understood the concerns relatives had and wrote to us shortly after the inspection and said, 'I feel the way they do about the past and we too do not want to forget this because it is necessary to improve and ensure that situations around compatibility do not occur again'. They shared a letter which would be sent to all family members inviting them to talk with the senior management team at a time which suited them.

The registered manager received continuous support from the provider organisation. Additional resources had been provided due to the highlighted concerns in 2016 and to support the recently registered manager. An experienced registered manager visited throughout the week. Their remit included general support and to observe staff practices. The locality manager also visited throughout the week. Their role included completing and recording monthly audits to assess the quality of the care provided and any matters relating to the maintenance of the home. Any highlighted areas were then actioned by the registered manager. For example, staff records were sampled and any supervision meetings needed were highlighted then actioned by the registered manager. Health and safety checks were carried out routinely such as on fire equipment, fire drills, infection control and fridge and freezer temperatures to ensure equipment and procedures in place were fit for purpose. Medicines were also audited weekly by senior staff. We noted one person's medicine on one day remained in their blister pack. A senior support worker was able to tell us this was because the person had been in hospital and an entry had been made in the audit carried out that week. This meant the medicine audit highlighted any changes, checked people received their medicines as prescribed and influenced the storage and safe returning of any medicines not used.

Pictorial satisfaction surveys had been completed with and on behalf of people living at the home to gain their views of how they felt about the care they received. Pictures of cartoon faces (emoji's) displayed an array of emotions and the person had to pick the one which represented how they felt. The ones we sampled completed in January 2017 had circled a big smiley face which meant they were very happy.

Staff understood their role and their responsibilities. They told us they felt supported by the management team and appreciated the additional time and resources provided by the company. A senior support worker spoke positively about the registered manager and told us, "If you are having a difficult time he will pull you to one side". They added, "It has been a difficult time but the staff team have really pulled together to support the service users through it. The home is 100% better". The same member of staff also shared the staff team could benefit from, "More positive reinforcements" from the senior management team with regards to their work when supporting people. We fed back this comment to the locality manager for their review. We asked the registered manager what was their greatest achievement so far they responded with, "People are much happier, staff are happier, going forward I want that to continue".