High Oaks Farm Limited

High Oaks

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10 November 2017. The inspection was unannounced. The last inspection to this service was carried out on 16 and 17 December 2016 and the service was rated as requires improvement. The service has, on all other inspections, been rated as compliant.

Following the last inspection the provider completed an action plan to show what they would do and by when to improve the service. The service required improvement in safe and well led. Concerns were identified in relation to the inadequate maintenance of the premises and equipment. Concerns identified by the inspectors had not been identified by the provider. We also identified a breach to Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because we found that the service had not always notified us of safeguarding incidents as required.

During our most recent inspection on the 10 November 2017 we did not identify any breaches and found this to be a well led and well managed service with a good rating in all the domains.

At the time of our inspection there was a registered manager who had been employed at the home since 2008. She was promoted to manager in 2010 and her registered manager status followed in 2011.

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.

In summary we found the service was managed well and benefited from a very experienced registered manager, and support manager. The director for the provider regularly supported the service and was familiar with people's needs and the needs of the service. Staff said they felt well supported and felt staffing levels were mostly adequate. However we felt staffing levels were not always sufficient to meet people's individual needs. One person required 1-1 support to go out during the day due to restrictions in place and others liked to go out with staff but at times in the day there were only two staff at the service. The director for the provider explained that some people had very poor mental health and lacked motivation to go out. They told us staffing levels were flexible and people had opportunities to go out some independently and additional staffing could be arranged where people needed support. People's access to the community was limited by the remoteness of the location and limited public transport, although the service had two cars it could use.

There were systems in place to ensure the service was clean and the risk of cross infection minimised. Equipment was serviced as required and there was a programme of refurbishment and replacement. Some of the bedrooms had ensuite facilities, and there were also shared bathrooms/toilets.

People received their medicines safely and as intended. Staff were aware of people's health care needs and

supported people to help ensure positive and stable mental health. People's needs were reviewed and care and support plans carefully documented people's needs and were reviewed regularly. People were consulted and involved in their plan of care.

Staff knew people well and were quick to act upon and report any changes including safeguarding concerns.

Staff received regular opportunities for support and training and demonstrated a good understanding of their role and people's needs. Induction for new staff was good. We found recruitment records did not show how staffs suitability for their role had been robustly explored and recorded which meant they had not followed their own processes.

Staff supported people lawfully and had a good grasp of the Mental Capacity Act 2005 (MCA). People received care, support and treatment after giving their consent. Staff engaged regularly with people and other health care professionals when providing people with support.

People were supported to eat and drink in sufficient amounts. The chef took a passion in the food they prepared and tried to encourage healthy eating. People had the opportunity to prepare light meals for themselves.

Support for people was provided by staff who were familiar with their needs. Activities were promoted but these were not always taken up by people using the service.

There was a clear complaints procedure and people's feedback was acted upon. There was an established quality assurance system which sought feedback as a mechanism for improvement.

The service was well managed with good leadership and oversight of risks and issues affecting the safety and wellbeing of people using the service were monitored and managed.

There was good engagement with professionals and some community engagement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

There was usually enough staff on duty.

Staff recruitment practices were mostly robust but there were gaps in record keeping so we could not see how the service assessed whether staff were of good character.

People received their medicines safely and as intended.

Risks to people's safety were assessed and reduced as far as reasonably possible. Lessons were learnt from adverse events to help ensure they did not reoccur.

Staff understood what constituted abuse and who they should be reporting it to. There was evidence that the service dealt with safeguarding concerns effectively.

The service was clean and the risks from cross infection minimised.

Is the service effective?

Good

The service was effective.

Staff were suitably supported and trained for their role.

People were supported to stay healthy and access healthcare services when appropriate.

Staff supported people lawfully and always gained people's consent.

People were supported to eat and drink enough for their needs.

The premises met people's needs but some restrictions were in place according to the level of assessed risk for each individual.

Is the service caring?

Good

The service was caring.

People were supported to make their own decisions and

involved in their plan of care.

People were encouraged to participate in the service and wider community.

People were independent but this was impeded by their environment.

Staff knew people well and supported them to access the right support.

Is the service responsive?

Good

The service was responsive.

People's needs were known and well documented to help ensure all staff worked consistently with people.

People's needs were kept under review to help ensure the support provided remained appropriate.

People were supported to develop positive mental health and partake in a range of different activities within the service and the community.

Is the service well-led?

Good

The service was well led.

The service benefited from a skilled manager and staff had a good skills base.

The service was well planned and managed well.

Lessons learnt from incidents, accidents and near misses were clearly documented.

There was an effective quality assurance system in place to improve the service based on feedback received.

High Oaks

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

The inspection was carried out as planned to follow up areas of improvement and non-compliance. The inspection was on 10 November 2017 and was unannounced. It was carried out by two inspectors.

In preparation for this inspection we looked at information we already held about the service. This included notifications, which are important events the service is required to tell us about. We reviewed "Share your experience" forms which gave feedback from people who used the service or their representatives. We looked at safeguarding notifications. Following the inspection we also reviewed the provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the registered manager, the support team manager, the director for the provider, the chef, three care staff, and five people using the service. We observed the care and support provided. We reviewed four care plans, medication records and other records relating to the management of the business.

Good

Is the service safe?

Our findings

At our last comprehensive inspection carried out on 16 and 17 December 2016 the service was rated as requires improvement overall with two key questions rated as requires improvement; safe and well led. The provider sent us an action plan following this inspection telling us how they had addressed our concerns. We found that these concerns had been addressed.

Recruitment records were not fully robust to demonstrate that the risks associated with employing unsuitable staff had been mitigated. We sought assurance from the Director for the provider that their practice will improve. They sent evidence following the inspection visits of actions taken to document any concerns relating to job applicants. A staff member told us they could not take up a position of employment until checks had been carried out and the necessary documentation was in place such as: driving licence, passport, utility bill, references and disclosure and barring check. Staff records showed interview notes and checks including a disclosure and barring check, satisfactory written references and an application form with checkable work history. The processes helped ensure staff with the necessary skills and attributes were employed.

Staffing levels were maintained across the day but reduced in the evening and at night-time. This reduction could put pressure on staff if multiple people required support at the same time. People were happy enough with staffing levels and told us they had individual time with their keyworkers each day and at least once a week went out with their keyworker.

We spoke with all staff working on the day of our inspection and they felt staffing levels were acceptable and they were well supported by management. We asked staff if they could meet people's individual needs and one staff told us this could be difficult when people wanted staff at the same time. Another said, "We could do with more staff; we spend a lot of time cleaning, not enough time for individual support." A staff member told us it could be difficult on night shift as there was only one waking night staff member and some people were up through the night and had irregular sleep patterns.

Throughout our observations we saw staff spending time with people and meeting their immediate needs. There was a lot of inactivity in the service with some people not engaging in planned or spontaneous activity. Some people stayed in bed throughout the morning. There was a daily meeting held at the service to agree what people wanted to do and how staff could facilitate this as well as detailed care plans demonstrating what support people needed. Some people chose not to join in anything and lacked routine and motivation. Staffing levels did not enable people to go out in the evening unless this had been planned in advance to ensure there was adequate staffing and transport available. We were told that people had been consulted about staffing levels and preferred to have more staff through the day so they could go out.

We were advised that one person required 1-1 staff support when going out and other people liked to go out with staff. Staffing rotas showed there were three staff on duty at any one time except for the night shift. At night there was one waking night staff member and a staff member sleeping on the premises to respond to emergencies should they occur. The person sleeping in worked until 11pm. Staff shift patterns included long

and short days, which meant there were two staff members on duty between 6pm to 7.45pm. This was to support 16 adults and meant evening activities unless pre-planned were restricted given the level of support people needed to go out.

We asked the director for the provider for assurances about staffing levels. They told us they were confident that they did provide enough staffing. They said both the manager and support team manager were knowledgeable about people's needs and would ensure their needs were met. They made this judgement through observational practice and spending time with people and staff. They said as they were both supernumerary they were able to help deliver care and support. They said in addition to care staff there was an administrator and a chef. They said that there was no evidence that current staffing levels impacted on people's safety or well-being.

At this inspection we found risks to people's safety were mitigated as far as reasonably possible because the provider had systems in place to help identify and reduce risk. Staff received the right training to support people with their mental health and there was sufficient oversight of incidents or anything affecting the safety and wellbeing of people. Monitoring and analysis of risk helped ensure lessons were learnt and the likelihood of a reoccurrence reduced.

We spoke with people about their living environment and about the day to day support they received from staff to help support their independence and reduce any unnecessary risks. They told us that they were well supported by staff. During our inspection visits staff were observed as having a good relationship with people and an understanding of their mental health needs. Peoples care plans gave a good insight into the person's personality and behaviours, which might put themselves or others at risk. There was documentation about how risks could be diverted, managed and reduced. In some instances just by staff knowing what people were doing and through regular observation, potential situations were avoided.

People were free to leave the service and at times did not return when expected or prearranged. Staff told us there were clear protocols in place to support this and regular liaison with the police if the person failed to get in touch. The provider ensured that the police were aware of people's needs so they could support them appropriately

There were policies and procedures regarding how to protect adults from potential harm and abuse. Staff received training to help them understand what constituted abuse and what actions they needed to take to keep people safe. This was balanced with people's capacity to make their own decisions however unwise. One person told us they felt safe. They said, "Staff are absolutely brilliant, all of them, I can talk to my keyworker, I don't feel threatened living here and I feel safe."

A staff member was able to describe a safeguarding situation. They told us they had made one referral when two people had argued and one slapped the other on the arm. They said the local safeguarding team were notified and they acted on the advice given. They also informed CQC as required. They were able to say what actions they had taken and how they monitored and kept both parties safe. They were also clear about what records they should keep. They told us they were comfortable in reporting concerns and had confidence in the manager.

People's personal records included information about their finances and guidance on how to best support people to manage their money without getting exploited. People told us staff supported them to manage money. There was also safeguarding/best interest information as well as a missing person's form. This included any pertinent information the police might need to know.

On arrival to the service staff told us about the fire procedures and the fact there was no planned fire drill. We were also asked to sign in so there was a register of who was in the building. Individual fire risk assessments and generic risk assessments were in place and seen.

There were safe systems in place to manage people's medication and ensure people received it as prescribed. We spoke with the staff member administering the medication who was knowledgeable and able to tell us about their training. Through observation of practice, the staff member demonstrated that they adhered to the services medication policies.

There were processes in place to assess if people were able to take their medicines independently. This was considered in line with people's mental health needs and the role regular medication had in helping people with positive mental health.

All medication was safely stored in locked cupboards in a secure room used as a clinic Medication that needed to be kept chilled was stored in a refrigerator that was checked frequently (usually daily) to ensure that the temperatures were within the recommended range. There was a separate safe in the clinic for the storage of controlled drugs. Controlled drugs were administered as required by two staff one who administered, the other witnessed and both countersigned the record. Keys were held securely. Administration of controlled drugs was checked and countersigned by two members of staff as required. Daily medication audits were carried out to ensure medicines were given as intended and there was sufficient stock. External audits from the pharmaceutical company also took place. This audit had identified some issues to be addressed by the service but there was a plan in place to do so.

We reviewed medication records of five people. All had a photograph of the person, room number, date of birth, and any known allergies. This helped to reduce the risk of misadministration. All charts were fully completed, signed, timed and dated. This indicated that people had received their medicines as prescribed. There was administration guidance in place for medication prescribed on an 'as required' basis. This helped staff know when it was appropriate to administer it, for example pain relieving analgesics. The staff used the back of the medication record to explain why medication was or was not administered which meant there was a clear audit trail. We noted that where people were prescribed medication for occasional use such as antibiotics there was guidance about this so staff were aware of any potential implications and reasons for its prescription. Staff received appropriate training in medication administration and management. Before administering medication they shadowed another member of staff. Only staff who had completed their online training and been assessed as competent were permitted to administer medication. Staff competencies were reassessed every year.

No medication errors were identified. Some people had not received their medicines at the time prescribed due to sleeping in but their medication was not time critical and staff observed sufficient gaps between each dose of medication.

Standards of cleanliness were acceptable and there were systems in place to reduce the risk of cross infection. Audits and schedules were in place and any shortfalls addressed in a timely way.

There was a culture of continuous learning and reflection on current practice to ensure it was up to date and improvements were made. Following an incident there was a review to help identify actions which would reduce the likelihood of it happening again. We reviewed all recent incidents within the service. They provided evidence of a full investigation into incidents and appropriate records being kept including body maps. Actions taken following an incident were proportionate to the level of risk. Some were around the interpersonal relationships between people and the conflict that sometimes occurred as a result of people

living in a communal setting. People were spoken with about their behaviours and what was acceptable and when necessary referrals to other agencies were made for further review of the situation and actions taken. In one instance, staff had taken advice from professionals about appropriate intervention strategies and identifying possible triggers to reduce the levels of incidents. Learning was shared across the staff team and care plans and risk assessments updated to tell staff how the situation should be managed.

The service had a full time administrator and access to computer systems was restricted to protect confidential data. The managers and the director for the provider were able to share information and review notifications, complaints and any pertinent information to ensure it was being managed appropriately. The director for the provider had a good oversight of the service.

Good

Is the service effective?

Our findings

At our last comprehensive inspection carried out on 16 and 17 December 2016 we rated this key question as good and, following this inspection, the rating remains good.

There were systems in place to ensure staff were adequately trained and supported for their role. This helped ensure they could meet people's needs and provide effective care. One member of staff told us they had previously worked in the care industry so were experienced. They said as part of their induction they had been shown round the building and introduced to people. They did a couple of shifts shadowing experienced members of staff. They said during their six month probationary period they got constant feedback from the manager.

They had completed some training which had been online. As part of their online training they had to read information and answer questions that were marked. They told us they had not had any face to face training but we sent the training matrix which showed all staff received a mixture of online and face to face training. One member of staff had not completed all their mandatory training but were still within their probationary period. They had not received training around managing difficult behaviours which some people using the service could exhibit. They told us they had not used physical restraint but would use diversion/distraction techniques and/or call the police. They also had not received any training in manual handling techniques as they said no one needed supporting with their moving and handling. However to comply with the Health and Safety at Work act staff need some training around manual handling and lifting loads.

All the staff we spoke with were very competent and had either worked in adult social care and mental health previously or had transferable skills. This meant they were able to demonstrate how they met people's needs.

The registered manager told us and we saw from the records viewed that training for staff included mental health awareness and dealing with behaviours which could challenge. Some staff had not had this because they were new to post. In addition bite size training sessions were provided at staff meetings around areas of interest and training requested by staff. We viewed the training matrix which showed when training had been completed and when it was due. Training included both in house training and access to external courses.

The staff worked in line with the Mental Capacity Act 2005 (MCA) and had a good working knowledge of it. The 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).

There was one DoLs authorisation which meant the person was not free to leave as they wished but required supervision for their own safety. The rationale for this was made clear. Everyone else was deemed as having capacity to make their own decisions and were free to leave the service as they wished. However it was recognised that some people needed support to access the community and this was part of their planned care.

One person had been refusing medication which had intensified some of their behaviours associated with their mental health. This was being monitored and we observed staff supporting this person effectively by using distraction techniques. A best interests meeting was being planned to review this persons care needs and medical treatment. This demonstrated how the staff were acting in the person's best interest. Another example given to us of how staff supported people was for a person who had been seen by the dietician. They had refused to act on their advice. Staff had explained to the person the risks of ignoring their advice and had reviewed the person's needs regularly. This was all recorded so we could see actions taken. Consent was sought before treatment and there was clear information about decisions taken and the rationale for these, particularly where people had made unwise decisions and against staff advice.

Consent to disclosure under the data protection act (i.e. to GP and other health staff, agencies that provide service to the person and housing agency staff) were in place. Records were signed and dated by a staff member and the person using the service. Consent to photographs and 'access to their records by family or carers' had also been agreed and signed permission received from the person using the service.

People were supported with their nutrition and hydration to ensure they had a balanced diet and were not at risk of unplanned weight loss or dehydration. We asked people about the food and they indicated it was good. One person said, "Well it's not caviar and champagne but its good." The chef communicated with people in terms of their preferences and dietary needs and this was recorded.

The service had a well-qualified chef. They had reorganised the kitchen and cooked wholesome nutritious food. They were aware of people's dietary needs. People were encouraged to access the kitchen to prepare light meals and snacks but this was subject to risk assessments, which looked at potential hazards such as infection control and sharp knives. We discussed this with the cook who said it was possible for people to be involved in meal preparation at other, (quieter) times of the day in preparing snacks or a light tea but not at lunchtime. We also observed portion sizes were quite large and we questioned this as one person had expressed their wish to lose weight. In their care plan there was nothing about how staff were supporting them with this. However the cook told us how they cooked all meals from scratch and encouraged people whenever possible to eat healthy food options, including plenty of vegetables and fruit.

We observed lunch being served. There were nine people in the dining room and food was served through a serving hatch. We noted that at the start of people's meal there were no staff other than the chef providing any support and several staff ate their meal when people had almost finished or after they had finished their meal. This did not enhance people's dining experience.

People were supported to stay healthy and access health care services as required. Care plans included a clear diagnosis and any medical conditions. There was a health risk profile and clear guidance about the impact an illness might have on a person if guidance was not followed both in terms of behavioural and physiological manifestations Additional healthcare information included smoking, alcohol, exercise, foot care, dental care, blood pressure, allergies.

Peoples care records provided evidence of regular health care appointments such as access to community psychiatric nurse, optician and dentist. We asked the registered manager about hospital admissions and

how this was managed given that some people had unstable mental health. Staff said they would always accompany people to hospital. However limited information was available to go with people to hospital and we suggested a one page profile and hospital passport might be a useful tool for the service to consider. Staff had been trained to take bloods and other minor procedures to help reduce the number of GP and or hospital visits necessary.

The premises were fit for purpose. On the day of our inspection, we found refurbishment was underway using known contractors. There was a clear plan of maintenance and they were upgrading windows, the porch and making other cosmetic changes. The building was laid out providing people with individual bedrooms some with ensuite bathrooms, shared bathrooms and lounge, dining area, games room and smoking area. The accommodation was all on ground level and there was a long corridor of rooms, which for a number of people said could be noisy. One person told us the water was not always hot and they had to wait. People had their own keys so had privacy in their room.

The service was in a remote location, which had both benefits and restrictions in terms of community access. The service had two vehicles, which could be used by staff to escort people. There was also some public transport. Trips out had to be arranged in advance to ensure there was transport and staff available. There was a communal laundry and communal kitchen and people had the opportunity to participate in laundry and food preparation.

Good

Is the service caring?

Our findings

At our last comprehensive inspection carried out on 16 and 17 December 2016 this key question was rated good and, following this inspection, the rating remains good.

People were treated with kindness and respect and we observed a good rapport between the staff and the people who used the service. Everyone we spoke with told us the staff were good and they felt able to approach them if they needed help or support around their needs. Support was identified as mainly around domestic skills, support around finance, maintaining good health and accessing the community.

We observed one person who was quite distressed and preoccupied with leaving the service. Another person was also anxious and required ongoing reassurance as we tried to talk to the other person. Staff were always close by to offer support and reassurance as well as helping people to move on from obsessional thoughts. Staff clearly knew people well and saw they had a positive effect on people's wellbeing. Despite the demands placed on staff their interactions with people were wholly appropriate and staff demonstrated patience.

We observed another person walking through the communal area who became quite abusive. Staff distracted them and met their individual needs and made requests in a calm, understanding manner. Minor altercations between people, mostly verbal, were observed but staff managed these situations well. Where altercations were of a more serious nature, staff managed these well and there was a detailed analysis of what worked well and what did not. Whenever possible alterations were diverted.

People were supported to make their own decisions and were involved in the planning and delivery of their care. People told us they had a key worker who they could speak with and who oversaw their care. A person said their keyworker took them out and people had regular one to one time with their keyworker. There were also daily meetings to discuss what was happening on the day and anything that was planned into the diary. Some people attended this but others did not.

People's privacy and independence was supported. Staff were mindful of people's needs and supported them as far as possible. It was accepted that some people needed support with personal care. One person was encouraged to have a shower and this took many attempts. Staff were positive in their approach and did not put any pressure on the person but revisited the subject at regular intervals. People made their own decisions and staff were skilful in redirecting people and working with them to help them reach sensible choices.

Good

Is the service responsive?

Our findings

At our last comprehensive inspection carried out on 16 and 17 December 2016 this key question was rated good and, following this inspection, the rating remains good.

People received care and support around their individual needs. Most people spoke favourably about their care. One person told us, "I love to shop; I like listening to music and doing art sessions". There were a number of things they told us they had done in the past but had not been able to continue these but had been given the opportunity.

People's needs were thoroughly assessed before being provided a service. We reviewed care plans and found them to reflect people's wishes and showed us how they had been consulted. Care plans were comprehensive, consistent and clearly laid out. There were helpful notes to assist staff in providing care for each person, for example with quick references for triggers to behaviours. Respect and gaining consent/encouraging were explicitly and implicitly included. The care plans highlighted people's needs and actions to be taken to meet that need. Where the person had declined the identified support this was recorded and kept under review. The care plans included aims: short, medium and long term. We were not always able to see the evidence showing how people had progressed towards their goal or encouraged to be more self-sufficient. For example one person told us they did not clean or cook because it was done for them. Some people wished to be more involved with meal preparation but this had to be considered in line with risks of them doing so. A person told us they wanted to go to college but could not find a college that fitted in with their preferences. No one at the service was involved in supported employment, but several people did vocational courses which helped them progress to greater independence.

Care plans included reference to behaviours and potential triggers and how these could be managed. They also gave guidance for staff on how to support people with aspects of their lives such as communication, medication needs, tissue viability, weight management, dietary & nutritional requirements, continence, emotional & mental wellbeing, self-neglect and any risks or concerns about self-neglect or exploitation. Religious & cultural needs were included as was information on sexual orientation/relationships. There was an environmental check list and any immediate risks from the environment and a crisis management & support plan.

With regards to end of life care, people's wishes and preferred priorities of care were discussed and recorded. However we noted that where people chose not to discuss it this was respected and recorded and staff revisited it with people on further occasions.

People's views were reflected in their plan of care. For example one record said the person liked to talk about their past. There was information about the persons past and how it was important to validate their feelings and listen but also how to move them on so they did not dwell.

People's needs were reviewed regularly and included detailed initial observations during the 72 hours following admission. Clear information was provided. Daily notes kept about each person also clearly

showed what support had been given and any activity the person had undertaken. Care plans were subject to regular review and annual update and included relevant professional input.

The service supported people to maintain their relationship with friends, family and the wider community. People were engaged in different activities appropriate to their needs. We saw some evidence of activities including participation in daily routines and light domestic duties. A person centred activities planner showed people had opportunities to get involved in a range of activities e.g. arts & crafts, music, street forge (woodwork and computers), shopping trips, and drumming. The service had an activities co-ordinator who talked to people to find out what interested them and tried to facilitate their interests. However the director told us some people had low motivation and a reluctance to join in anything provided or suggested.

The recent 2017 survey showed 77% of people rated activities as good or very good. The service engaged with people daily to establish what they would like to do and when possible tried to accommodate their needs. However two staff spoken with felt additional staff would help them be more responsive to people's needs. This was discussed in the context that people did not all have needs that were compatible and preferred 1-1 time with staff. Those who could go out independently did so and there were clear guidance and risk assessments in place.

We spoke with one person and asked what their plans for the day were. They said, "Just chilling." We asked what they were doing at the weekend, they said, "Nothing. "They then told us they would like a befriender, someone they could do things with regularly who was the same age and shared the same interests as them. We passed this over to the registered manager as it was not something that had already been identified. One person said, "I don't do nothing I'm retired but I go into town, tidy up for myself. I'm left to my own devices". "They made it clear they did not want to work or go to college and were happy living in the countryside. Another said when asked what they do, "Not much, I get a bit bored." Another person told us they were too tired to participate in anything but said they helped with odd jobs but could not tell us anything they had done recently. They said they would like to cook but was not 'allowed.' One person told us they got one to one support from staff weekly and were supported each day with their needs and interests Staff told us alternative trips were planned such as church one weekend and car boot sale the next. We asked how this supported an individualised approach and were told it is what people had requested they do.

On the day of the inspection, an experienced musician was providing entertainment for people. They also played instruments and encouraged people to learn to play but said there had not been much interest. We observed a small group of people enjoying the session. The service had alternative areas for people to use if they did not want to participate. The staff told us they also had arts and crafts, reflexology, music and exercise. Staff did say people could get buses, taxis or use their transport to get into town but had to see who else was using the cars or if any appointments were booked. One person went swimming regularly and some people had regular input from families. Staff told us they had tried to engage the local community and had held a fete in the summer and raised money through a barbeque and other things. The money raised was split between two local charities. We asked about college as one person had said they wished to do this but they had not found a course to enrol on at a time of their choosing. Two people were involved in vocational courses: woodwork, computing and gardening.

There were systems for people to feedback their care experiences, both positive and negative. There was an established complaints procedure. There had been no formal complaints over the last year. However there had been concerns raised by a member of staff and this had been dealt with in an open and honest way and recorded as such although it was not an official complaint.

Good

Is the service well-led?

Our findings

At our last comprehensive inspection carried out on 16 and 17 December 2016 this key question was rated as requires improvement with one breach. The breach was for Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The service was not always notifying us of incidents occurring at the service. This is important as inspections are based on risk and we rely on services to tell us what is happening The provider sent us an action plan telling us how they had addressed our concerns. At our most recent inspection, we found the service compliant.

The service was well- led with good leadership and governance. At the time of our inspection there was an experienced registered manager who was well supported by both a support manager and the director, all were present during the day. The service had both a residential service and supported people within their own homes. However, this service was not registered as they were not providing a regulated activity. The home service was to support people to develop their confidence and life skills and not to provide personal or nursing care.

The service was managed effectively and there was a clear oversight and management of risk and quality control. Risks posed by both the environment and individual risks were well managed. There were environmental risk assessments and plans in people's care plans recording how risks to people's safety should be addressed. Risk assessments included, what, when and how a risk should be managed. There were clear objectives and these were reviewed and included a plan to promote positive mental health and a crisis plan if a person's health worsened.

The registered manager told us they kept themselves up to date and had a professional registration so had regular clinical updates. They said they attended provider forums and attended conferences and training as available.

Staff told us they felt well supported and there was good back up out of hours and weekends. Staff and people using the service knew the registered manager and the director for the provider well. The registered manager worked flexibly according to the needs of the service. A second manager (Support Team Manager) also worked some of their hours outside of the rota. They, like the registered manager, worked as needed and undertook one to one work with people including providing counselling support.

The service had links with stakeholders and the community in which the location was situated. The service held events and encouraged community participation and also supported and encouraged people to attend different events and activities. Some people had regular contact from friends and family where others had limited or no contact. The service did not currently have any volunteers to support people who might be isolated.

The service continuously reviewed what it did for the benefit of people using the service and to ensure the service was progressive. Staff told us they were familiar with what we looked at as part of our inspections as the director for the provider discussed this and did mock inspections. They had devised action plans to

show how they had continuously improved the service based on observation of practice and feedback. The last surveys issued as part of the service overarching quality assurance process was issued in June 2017 and showed mostly positive feedback. The surveys were given out on a rolling programme and took into account feedback from people, staff, relatives and professionals. The director told us that they got positive feedback from other stakeholders particularly around helping people settle who traditionally had not settled in other placements.

Risks to people's safety were reduced as far as reasonably possible and there was planned and routine maintenance of the environment and equipment used. Regular meetings were held with the staff, the management team and the director for the provider was hands on. We saw there was detailed analysis of accidents, incidents and near misses. We reviewed cleaning audits and schedules, as this was a concern last time. The service was clean and audits identified any concerns. We saw food surveys were used to ascertain people's dining experience and rating of the food. We viewed environmental risk assessments, which included the fire procedures and maintenance of equipment. We viewed the electrical installation records, gas safety and water safety and record of temperatures. All were completed well.