Healthlinc Individual Care Limited

Bradley Apartments

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bradley Apartments provides accommodation, nursing and personal care to a maximum of 14 younger adults with a learning disability, some of whom may also have needs associated with their mental health and autism.

The service is purpose built and comprises of a range of two, three and four bedded apartments with kitchens and living areas on the first floor, there is an activity room and lounge area on the ground floor. The service is located on the same site as Bradley Woodlands Hospital on the outskirts of Bradley, which is on the south western edge of Grimsby. Bradley Apartments has an allocated garden area in the grounds. Both services are part of the same organisation.

On the day of the inspection there were eight people using the service. Another person was visiting the service for day-care support. People have varied communication needs and abilities.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When Bradley Apartments opened in 2014 a 'clinical lead' was appointed and given delegated day-to-day management responsibilities for the service and they reported to the registered manager. In October 2015 the clinical lead took the decision to resign their position and the deputy manager from the adjoining hospital site took over the day-to-day management of the service. A decision was made by the organisation to recruit a new manager for Bradley Apartments who would apply for registration with CQC; they considered the service would benefit from having their own registered manager who could focus on developing the service and establishing a clearer identity from the adjoining hospital service. The new service manager was appointed and commenced work at the service on 11 January 2016.

We found the registered provider had not always met the requirements of the Mental Capacity Act 2005. People's consent was not always sought about the care and support they needed. Staff were using physical interventions with one person to manage their behaviours that challenged the service and we found there was no capacity assessment record and best interest decision records in place to support this approach. We also found the management team had made changes to the occupancy arrangements in some apartments without consulting the people who this affected, their relatives or relevant care professionals.

There were times when there were not always enough staff deployed to meet the needs of people. High staff turnover and staff sickness levels contributed to the staffing shortfalls and maintaining the continuity of care. Staff had not received all the support, formal supervision and appraisal they required over the last 12 months.

This meant the registered provider was not meeting the requirements of the law regarding consent and staffing. You can see what action we told the registered provider to take at the back of the full version of the report.

We found staff were recruited in a safe way; all checks were in place before they started work. The staff had received an induction and essential training at the beginning of their employment and we saw this had been followed by some periodic refresher training to update their knowledge and skills. We found shortfalls in training to meet the needs of individuals such as: epilepsy management, specific communication techniques and understanding autism, but saw that arrangements to address this shortfall had been planned.

There were policies and procedures in place to guide staff and training for them in how to keep people safe from the risk of harm and abuse. In discussions, staff were clear about how they protected people from the risk of abuse.

Assessments of people's needs were completed and care was planned and delivered in a person-centred way. The safety of people who used the service was taken seriously and managers and staff were well aware of their responsibility to protect people's health and wellbeing. Risk assessments had been developed to provide staff with guidance in how to minimise risk without restricting people's independence. People we spoke with told us they felt safe living in the home.

Positive behaviour plans directed staff to support people's behaviour that challenged the service effectively. Social care professionals considered some people had made very positive progress in this area. Robust systems to monitor and review all incidents were in place.

Some people participated in a range of vocational, educational and personal development programmes at community day services. People also accessed a range of activities in the service and in the community, although staffing shortages had impacted on this recently. They were encouraged to follow and develop social interests and be active and healthy. The programmes and support were geared to maximise the person's independence.

Staff had developed good relationships with people living at the service and respected their diverse needs. Staff knew people's individual care and support needs well. People told us staff looked after them well, were kind and caring and respected their privacy and dignity. Staff supported people to maintain their relationships with friends and family.

The environment was accessible and safe for people. Equipment used in the home was serviced.

We saw arrangements were in place that made sure people's health needs were met. The service worked closely with community healthcare teams. Medicines were stored safely and people were given their medicines at the right time in a safe way.

We found people had enough to eat and drink, and we found improvements had been made to the specialist diet provision for one person to ensure their needs around swallowing were being met consistently and safely.

People felt their concerns were taken seriously, and we saw where complaints had been made these had been addressed and acted upon.

The registered provider had systems in place to check and audit the quality of the service. People who used the service, relatives and staff were able to express their views on how the service was run and felt their comments and suggestions were taken seriously.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The registered provider had not always ensured there were enough staff deployed to meet the needs of people.

Risks were regularly reviewed and, where appropriate, acted upon with the involvement of other professionals so that people were kept safe.

Staff knew how to keep people safe from harm and abuse and how to report any safeguarding concerns.

Medicines were managed, administered and stored safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Suitable arrangements were not always in place for people to consent to their care and support or for staff to follow legal requirements when people could not give their consent .

Staff had access to a range of training. Records showed some gaps in training to meet people's individual needs and conditions, but further courses had been planned and scheduled. The supervision and appraisal programmes had not been effectively maintained. Some staff felt they had not received adequate support due to the staff and management changes.

People experienced positive outcomes regarding their health; healthcare needs were met and monitored and other healthcare professionals were appropriately involved when necessary.

Is the service caring?

Good

The service was caring.

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

People were treated with respect and their dignity and privacy was promoted.

People were encouraged to be as independent as possible, with support from staff.

Is the service responsive?

Good

The service was responsive.

People received care and support in accordance with their preferences, interests, aspirations and diverse needs. People and those that mattered to them were encouraged to make their views known about their care, treatment and support.

People were supported to access community facilities and were encouraged to participate in meaningful activities and occupations within the service. They were enabled to maintain relationships with their friends and family.

People and their relatives understood how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff morale had dipped in recent months with management and staff changes; however staff were positive about the appointment of the service manager, new qualified staff and improvements in the day-to-day management.

The culture of the home enabled people to take positive risks to develop their independent living skills. People were able to express their views and felt the registered manager and registered provider would listen to them and take action to improve things.

Regular quality checks and audits had been completed using corporate monitoring tools, however, we found shortfalls with the staffing numbers on shifts, staff supervision and support and compliance with the Mental Capacity Act 2005.

Bradley Apartments

Detailed findings

Background to this inspection

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

This inspection took place on 4, 10 and 12 February 2016 and was unannounced.

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

We usually send the registered provider a Provider Information Return (PIR) before an inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the registered provider before this inspection. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

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

During the inspection we observed how staff interacted with people who used the service. We spoke with four people who used the service. We spoke with the registered manager, the operations director, the new service manager, a deputy manager from the hospital (who had provided clinical lead cover for two months) two nurses and four care workers.

We looked at eight care files which belonged to the people who used the service and a care file for one person who had recently been transferred to a new placement. We also looked at other important documentation such as eight medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

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

Requires Improvement

Is the service safe?

Our findings

The four people we spoke with told us they felt safe at the service. Comments included, "Yes, I'm safe here, they look after me" and "I like living here, it's safe."

When we talked with people who used the service and their relatives about the staffing levels and staff changes, we received some mixed comments. One person considered there were sufficient staff on duty and told us, "Staffing seems alright, there are always staff in their apartment." But the remainder felt the numbers of staff weren't consistently maintained and this had at times affected their family member's opportunities to attend day services and activities. Comments included, "He's missed going to Foresight a few times recently and that's not all him refusing, it's mostly down to them not having enough staff to take him. Routine is so important to [name], he does get anxious if he doesn't go", "He's regularly missed his swimming activity because there's no staff to take him", "They have had limited access to activities in the community" and "So many of the nurses have left, they have had to use lots of temporary staff."

During our last inspection of the service in March 2015 we found the registered provider did not have suitable arrangements in place to protect people from the risks associated with the water system and fire safety measures. Subsequent to that inspection, the registered provider sent us an action plan to tell us how they were going to improve the service.

At this inspection we found improvements had been made and a current certificate of inspection was in place in relation to Legionella. Records showed that all water outlets were flushed regularly with shower heads cleaned regularly to reduce the risk of infection. We also found fire safety arrangements were included in the staff induction training and staff were shown these when they commenced work at the service. We spoke with one new member of staff who confirmed they had been shown the fire safety procedures on their first working day at the service. Qualified staff we spoke with confirmed they were aware of the manual over ride mechanism with the fire safety doors.

There had been some significant management and staff changes in the service over the last five months. The clinical lead had resigned their position and the majority of full time qualified staff had left the service. The deputy manager from the adjoining hospital service had taken over day- to- day management until the newly appointed service manager commenced work in January 2016. The service had used a high number of bank and agency qualified staff; the registered manager told us they tried to use temporary staff who were familiar with the service but that this had not always been possible. There had been some turnover of care staff and staff sickness rates had been high. All this had resulted in some continuity of care issues. For example, one person with specific communication needs did not always receive support from staff who were competent in communicating effectively with them. Also some people were not accessing their community activities as often as planned. One member of staff told us, "It was so disappointing when [name of person] couldn't attend their first day at Foresight (a community resource centre). We had worked so hard to persuade and encourage them to go, supporting them to buy new clothes and on the day, they were dressed and ready to go and there weren't enough staff on duty to take them. They were really upset, we all were."

The registered manager informed us the staffing hours each person required was agreed with the commissioning teams prior to the person's admission and this was reviewed on an on-going basis. They told us and records showed some people had one-to-one support hours in place when in the service and required two-to-one support when accessing the community. The registered manager confirmed in November and December 2015 the dependency and occupancy levels had determined numbers of six staff for the day shifts and four at night. Records for December 2015 showed four day shifts and five night shifts did not have sufficient staff on duty to meet these required levels. The registered manager also confirmed and records showed when two new people were admitted in January 2016 the staffing levels increased during the day to seven staff. The service also accepted the admission of an emergency respite placement for a week in February 2016. However, records showed shortfalls in staffing levels on seventeen of the day shifts and eight night shifts in January 2016 with continued shortfalls up to and during our inspection visits in February 2016.

These shortfalls in deploying sufficient staff meant there was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the action we have asked the registered provider to take can be found at the back of this report.

We found there was a satisfactory recruitment and selection process in place. The staff files we checked contained all the essential pre-employment checks required. This included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

During the inspection the registered manager confirmed they had recently recruited two new qualified staff and appointed two senior support workers. Further recruitment of qualified and care staff was planned. The registered manager also confirmed they were introducing an induction programme on site for agency staff to ensure they understood all the safety procedures.

The environment was seen to be safe for people who used the service. Equipment used was maintained and serviced in line with manufacturer's instructions. The registered manager confirmed maintenance staff were now employed in the service for one day each week to carry out the routine safety checks and maintenance work, any additional hours would be provided as required. All people who used the service had evacuation plans to guide staff and emergency services in how to move and handle people safely and quickly when required. Staff had completed first aid training and there was a first aid kit, portable defibrillator and oxygen in the service to support emergency care support. We saw the service was clean, tidy and well maintained throughout.

The registered provider's safeguarding adults and whistle blowing procedures provided guidance to staff on their responsibilities to ensure that people were protected from abuse. Staff understood the procedures to follow if they witnessed or had an allegation of abuse reported to them. They also understood they could escalate concerns to external agencies if required, and considered they would be supported appropriately. Staff told us they had received training in safeguarding adults from abuse. Records showed safeguarding referrals and alerts had been made where necessary and feedback from the adult safeguarding team demonstrated the service had cooperated fully with any investigations undertaken or overseen by the Local Authority.

Risk assessments were in place which identified a number of hazards such as behaviour management, accessing the local community, falls, mobility and choking. This meant that information was available to inform staff of what actions needed to be taken to minimise risks and avoid harm. Records showed where

there were concerns about individual's risk management the service had involved appropriate agencies for advice and support.

People received their medicines safely and as prescribed from appropriately trained staff. We checked the medication administration records (MARs) for the eight people who used the service and found these were recorded accurately. When people were prescribed medicines to take 'when required', there was guidance for staff. This type of medication may be prescribed for conditions such as pain, anxiety or specific health conditions that required emergency rescue medication. No one was self-medicating on the day of our inspection.

A member of staff confirmed they had recently reorganised the clinic room, changed arrangements for prescription collection and the service had changed pharmacy providers which had all made significant improvements with the day-to-day management of medicines. Regular medication audits were completed to check medicines were obtained, stored, administered and disposed of appropriately. Only qualified nursing staff administered medication and were able to evidence they had the skills needed to administer medicines safely.

Requires Improvement

Is the service effective?

Our findings

People told us they liked the meals. Comments included, "We get to plan the meals and help with the cooking. I like going out for meals as well", "I cook my meals" and "The meals are nice, staff help us with healthy eating, but I don't like salad much."

Relatives told us they thought people's health needs were well maintained and that staff were skilled in looking after them. Comments included, "Yes, they always contact the GP or the emergency services if necessary" and "They monitor his health closely, I've been impressed with that." A relative said they weren't always informed now about incidents such as seizures but staff had always been good about that in the past.

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. From discussions with staff and records seen we found the principles of MCA had not been applied consistently and lawfully. For example, staff currently used physical interventions with one person to support the management of their behaviours which challenged the service. There were no records to demonstrate an assessment of capacity had taken place regarding the person's ability to understand and consent to this and no best interest meeting decision was recorded about this. In discussions a member of staff told us they administered one person's medication in their food but we found associated capacity assessment records and best interest decision records were not in place.

Relatives for two people who used the service told us they had not been consulted and nor had their family member , when there had been changes to the occupancy arrangements in some of the apartments. They told us staff had supported some people to move to different apartments, which they felt was to facilitate new admissions to the service. A relative said they considered the arrangement was working out but initially they had been very concerned as the person who moved in with their family member had very complex needs around their behaviour and could be aggressive.

These shortfalls demonstrated in ensuring consent to care and treatment meant there was a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the action we have asked the registered provider to take can be found at the back of this report.

The registered provider had completed some mental capacity assessments and best interest decisions regarding people being able to leave the service and accepting care and support from the care workers. The registered provider had ensured that family members and relevant health and social care professionals had been consulted with regarding these decisions.

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 services are called the

Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager understood their responsibilities in relation to DoLS and applications had been and were being made to the supervisory body which, as far as was reasonably practicable, ensured if people were deprived of their liberty it was done lawfully. Records showed five authorisations had been applied for and granted, one application had been denied and further applications were being made for two people. We looked at the care plans to check what action had been taken to ensure the people were cared for using least restrictive practices. We saw the restrictions were required to keep the person safe.

We discussed support and supervision with a range of staff and received mixed responses from them. Some staff felt they had not received regular supervision but could access support from the qualified staff and clinical lead when necessary. We spoke with two staff who considered they would have benefitted from more formal supervision from their line manager over the last six months due to the changes within the service and the complexity of needs with the new clients admitted. Another member of staff told us they had considered leaving as they felt there had been little support from senior staff with so many leaving. Records showed the majority of staff had received one formal supervision meeting whilst working at the service but this was not in line with the registered provider's policy of providing supervision every three months. We also found only six staff had received an annual appraisal; records showed 19 staff who had not had an appraisal of their performance had been employed longer than 12 months.

These shortfalls in ensuring staff receive adequate supervision and appraisal meant there was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the action we have asked the registered provider to take can be found at the back of this report.

The training records showed staff had completed a range of essential and refresher training, the courses included: fire safety, food hygiene, first aid, safeguarding, equality and diversity, infection control, MCA, Mental Health Act and training on the management of behaviours which challenged the service, including physical interventions. Staff told us the induction programme was comprehensive and included shadowing more experienced staff before they were allowed to provide care to people unsupervised. The programme followed a nationally recognised set of induction standards for social care staff.

Staff also told us they received a range of on-going training to develop skills in line with the needs of the people who used the service. For example, training was provided on subjects such as learning disability, autism, epilepsy, signalong, positive behaviour support and intensive interaction therapy. Records showed many of the staff had not completed some of these courses, for example only seven out of 36 staff had completed training about autism and 18 staff had completed training in epilepsy management. The manager attributed this to staff turnover in recent months. They confirmed they had recently met with the registered provider's training officer to discuss this shortfall and plan a revised training programme. Some of the courses were provided by community health care professionals and records showed additional training from this team had been arranged in relation to communication for one person.

We received some mixed comments from health and social care professionals involved with the service. Three care professionals we spoke with gave us positive comments about how well staff managed their client's health needs but two of the professionals we spoke with considered staff turnover had affected the consistency of some aspects of care support for people around nutrition and communication. The registered manager confirmed they were looking to provide a core staff group for one person who would be skilled and competent with meeting their specific communication needs.

People's day to day health needs were being met had they been referred to health professionals for

assessment, treatment and advice when required. These included: psychiatrists, psychologists, GPs, dieticians, speech and language therapists, emergency care practitioners, specialist nurses for epilepsy management, podiatrists, dentists, and opticians. Records indicated people saw consultants via out patient's appointments, accompanied by staff, and had annual health checks.

We saw people's nutritional needs were assessed and kept under review. We saw people had their weight monitored and appropriate action had been taken when there were concerns. Where people were at risk of choking or malnutrition they had been assessed by the speech and language therapist and dietitian. We found guidance and direction for staff was provided in the care files and people's apartments. Care professionals for one person had raised concerns about staff not providing suitable high calorie snack food options for them to take to day services. During the inspection we saw the service manager had addressed this issue and provided staff with updated lists of suitable foods to purchase and provide for day care, which they were monitoring each day.

Staff told us they worked with people to produce individual menu plans each week and encouraged healthy eating. Once agreed, menus were prepared for breakfast, lunch and the main evening meal but they told us these were subject to change if people who used the service wanted something else. Some people who used the service were encouraged and supported to be involved in shopping for food. One relative told us they were becoming concerned about their family member's weight gain and had started to bring in some healthy meal options.

Good

Is the service caring?

Our findings

People who used the service were positive about the care and support they received. They told us the staff were kind and provided the help that they needed. They told us staff respected their privacy and dignity. Comments included, "I can tell staff not to come in and they don't come into my room", "Staff are nice and friendly. I like [name of member of staff] best, he helps me do jobs and things" and "Staff are caring."

Relatives spoken with told us, "The staff are great, they are caring and patient, I can see they are very fond of the residents", "Majority of staff are excellent", "The staff changes have been upsetting, some of the long standing staff are still here but many have left. It takes time for us to build up the positive relationships we had, I'm sure [name of person] misses them too."

We observed people were happy and at ease with staff and we saw that staff had a good rapport with them; staff demonstrated understanding and kindness. The staff explained to people the purpose of our visit, responded to any queries and were alert to any changes in people's behaviour. When we conducted a tour of the service we saw further explanations and reassurances were given to people before we accessed different areas. The staff we spoke with had a good knowledge about people's backgrounds, their current needs, strengths and anxieties and the type and level of support each person needed.

Independence was promoted and staff provided active and individualised support that enabled people who used the service to participate, where they were able, in day to day living activities such as shopping, cleaning, laundry, cooking and bed changing. We saw people who used the service looked well cared for, were clean shaven and wore clothing that was in keeping with their own preferences and age group. Staff told us the people who used the service were always supported where possible to make their own selections of clothing and other purchases, for example toiletries.

We observed people who used the service in the company of the staff and found staff communicated effectively and people reacted positively to interactions. For most of the inspection people presented as calm and comfortable, smiling and enjoying friendly interaction with staff when engaged in daily activities or discussing their plans for the day. One person we noted became very elated at regular times. They were reassured effectively and a challenging situation was averted by staff communicating well with the person and focusing them on completing a task or moving to another area. We were present when another person became agitated, upset and demonstrated behaviours which challenged the service. We observed staff remained calm and supported the person appropriately, successfully de-escalating the situation. They managed the situation well and senior staff were present to provide additional support.

We saw people's privacy and dignity was respected. We observed staff knocked on people's bedroom doors and waited to be invited in. The observation windows in people's doors had been appropriately covered up and staff confirmed they were not used. During the inspection visit we found all staff treated people in a respectful way. People chose whether they wanted to be in communal areas or have time alone in their room and these decisions were respected by staff. Staff spoke to us about how they promoted people's privacy, dignity and independence and gave examples of good practice. They said, "We always support

people with their personal care in their bedroom or bathroom, in private and we always knock on doors and treat people with respect, as you would want to be treated" and "We encourage them to do things for themselves and some people need more encouragement, support and direction than others."

Bedrooms were personalised with people's own belongings and they were encouraged and supported to individualise their rooms with items they favoured and which meant something to them, where appropriate. Some people's rooms contained few items in line with their preferences and needs. One person told us, "I like my photographs on the wall and staff helped me with this." The environment provided facilities that enabled people to live a normal lifestyle within a risk management and rehabilitation programme. We found more homely touches around the service such as cushions and pictures. The long term goal for people, where able, was to relearn and develop independent living skills to enable them to move on to a more independent lifestyle within a supported living arrangement.

Staff told us about the importance of maintaining family relationships and supporting visits and how they enabled this. People could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wanted or there was a meeting room for this on the ground floor. When necessary, staff had assisted people to keep in touch with relatives by sending birthday and Christmas cards. Relatives we spoke with told us staff were always welcoming when they visited and provided refreshments. One person's relative said, "Sometimes we bring my grandchildren in to visit and we find it more appropriate now to use the visitor's room. It also means [name of person using the service] does have to motivate themselves a bit more and leave their apartment, which is always good."

We saw people were provided with information. There were notice boards in the entrance and in the corridors in the service. We found information was provided about keeping people safe, complaints, fire safety and introducing the new manager. Photographs of all the staff working at the service were provided in the entrance. Records showed a resident's meeting had been held in December 2015.

The registered manager and staff were aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. We found records were held securely. The registered manager confirmed the computers held personal data and were password protected to aid security. Staff had completed training about information governance in their induction.

We saw advocacy services were used to support people when required.

Good

Is the service responsive?

Our findings

People told us they were happy at Bradley Apartments. Comments included, "I'm happy. Staff help me to be more independent. They give me time to do things and I like to go fishing, go for drives and cook my meals", "I like my apartment, I've made friends and read my care plan", "I make a shopping list and they go and buy everything."

Relatives told us, "In terms of care support and managing their behaviour this has been the best service so far. They feel really safe and secure here and staff have supported this" and "This is the best we have found [name of person]they go out more than before and the staff are getting better with encouraging and motivating him to participate in some daily living activities."

Health and social care professionals we spoke described the progress some people had made whilst living in the service. One told us how their client's behaviours had significantly improved and they were developing skills to manage these much more effectively. They described how well staff followed the person's positive behaviour support plan and engaged the person in positive activities and tasks so they were more fulfilled. Social care professionals also told us about the positive transition work the staff had completed to support one person's recent discharge to a supported living placement and two new admissions to the service.

During our last inspection of the service in March 2015 we found the registered provider did not have suitable arrangements in place to ensure people's needs were appropriately assessed and planned. Subsequent to that inspection, the registered provider sent us an action plan to tell us how they were going to improve the service.

At this inspection we found improvements had been made to the quality of recording in people's care plan records. The service manager confirmed he had worked through each person's support plan with the qualified staff and updated these where necessary with current information. We looked at the care files for each of the people who used the service. Their support plans focused on them as an individual and the support they required to maintain and develop their independence. We saw the information in care plans was detailed and provided staff with guidance. For example, their preferred daily routines, what they enjoyed doing and how staff could support them in a positive way. Each person had a detailed communication plan.

Two of the files for people who had recently moved to the service contained transition plans provided by the person's care manager and the majority of information in the files was from their previous placement. One person's relative had provided a very detailed 'My Life' book which contained lots of information about the person's family and interests, their likes and dislikes and how they communicated. The book contained a lot of photographs and gave staff a good level of information and understanding about the person. The manager confirmed the staff built on the transition plans and following the care review meeting with the person's representatives and care management team, a formalised and agreed support plan would be put in place.

The registered manager described the pre-admission processes which had supported recent admissions. Staff had spent time visiting both people in their previous placement getting to know them and developing a relationship. Relatives of both people told us how their family member had settled in the service and social workers agreed the moves had gone well.

We looked at the care plans and risk assessments for one person with complex needs around their epilepsy and mobility. We found staff had completed all relevant risk assessments such as moving and handling, falls and pressure damage. We looked at another person's positive behaviour support plan and found this included clear proactive and reactive strategies to support effective communication, life skills and keep the person and those around them safe whilst using the least restrictive option. The person was supported to be involved in work activities and we saw the activity board in their apartment. It was pictorial and detailed all activities and tasks to be completed each day. The person's behaviour support plan indicated the programme was reviewed each Sunday and praise given for achievement and the person received wages if all jobs were completed. They told us, "I do lots of work like cleaning the cars and things. I like being busy and helping. I get wages."

We saw each person had a health action plan which detailed their health care needs and who would be involved in meeting them. This helped to provide staff with guidance, information about timings for appointments and instructions from professionals. In addition, each person had a 'Hospital passport.' These records contained details of people's communication needs, together with medical and personal information. Discussions with one person's relative identified the document had not been sent with their family member during a recent hospital admission. We passed this information to the service manager.

Daily records contained information about what people had done during the day, what they had eaten, how their mood had been or if their condition had changed. The organisation was in the process of introducing an electronic care records system. Each person's support plan and daily records had been transferred over so far, although handwritten records were still being maintained until the system was fully implemented. Records showed some care records had not been evaluated consistently and the service manager confirmed they had introduced a new named nurse system and records had been allocated to the nominated member of staff to review and maintain.

The service manager confirmed they had reviewed the organisation and use of the service transport for community access as there were no clear systems in place when they started. They also confirmed they had reviewed and updated people's activity programmes to ensure they met the person's needs and to provide a more co-ordinated approach with available resources.

Support was provided that enabled people where able to take part in and follow their interests and hobbies, this included access to the local community. Some people accessed regular day services where they participated in a range of recreational, occupational, therapeutic, educational and sensory activities. Some people were funded to have additional staff hours when supported in the community. For example, during the inspection a person went out for several hours on a one- to-one basis with staff to feed the ducks at a local park whilst others went shopping. Discussions with staff, people and their relatives identified the community facilities accessed included local discos, sports activities with a wellbeing group, swimming, bowling, cinema, fishing, pubs, shops and cafes. There were also activities and meaningful occupations completed in-house. These included, baking, helping to prepare meals, assisting with personal laundry, cleaning, arts and crafts, games, watching television/DVD's and listening to music. One person assisted a member of staff with some health and safety checks.

People's social workers told us that discussions had been held in review meetings about opportunities for

some people to have a holiday or access alternative planned days out. Arrangements for such were currently being considered.

There was a complaints policy and procedure and staff were familiar with the actions to take if they received a complaint or concern. The policy and procedure was in easy read format to help the people who used the service to understand the contents. One person who used the service told us they would fill out a complaints form and give this to the manager if needed. We found four complaints had been received in 12 months and they had all been acknowledged, investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

People who used the service told us they had met the new service manager. One person told us, "I like the manager; I speak with him every day." Relatives told us there had been lots of changes with the management and staff over the last few months and they hoped things would settle down again.

Professionals we spoke with described how good the service had been when the clinical lead had been in post but felt aspects of the management of the service had slipped recently due to the management and staff changes. They told us the appointment of the new service manager was already making a difference and considered communication had improved and they kept them better informed about their client's care and wellbeing. One professional told us they were impressed with the manager's focus on ensuring the person who used the service was central to the service delivery and ensuring positive, agreed outcomes.

The service manager had been appointed four weeks prior to the inspection and confirmed they had completed their induction to the organisation. Within this time they told us they had reviewed aspects of the day-to-day organisation, people's care needs and prioritised key areas of improvement. They described how they had identified communication issues, low staff morale, staff changes and dynamics that required attention to ensure the team worked well together. Recruitment of qualified and care staff was a priority, they also identified improvements were needed to the records systems and better organisation of community activities, including apartment shopping and transport arrangements. We found some progress had been made in these areas already.

The service manager described his management style as open and transparent. His approach would be inclusive through consultation with people who used services and their representatives, staff and partner agencies, and we saw some evidence of this. He confirmed he would be working on a comprehensive action plan to support continued improvements and development of all aspects of the service.

The registered manager for the service also managed the adjoining low secure hospital service. When we last inspected this service we found the registered manager was not particularly visible and there was little evidence of their input into the day-to-day running of the service. At this inspection we found the registered manager had more involvement with the management of the service; they had provided support to the clinical leads on a daily basis and had more involvement in the daily clinical and management decision making.

Records showed the registered manager had taken action to tackle the high rates of staff sickness. Return to work interviews were being completed and individual absence from work was being monitored more robustly. The registered manager confirmed disciplinary action had been taken in some cases.

Staff told us that the registered manager and new manager were approachable and supportive. Records showed some staff had received letters in recent weeks from the registered manager thanking them for their support and professional approach, for example when there had been staffing shortages. Records showed staff meetings were held monthly and newsletters were produced each month to give staff additional

information and updates. The ones we reviewed covered topics such as: staff changes, dress codes, health and safety, sickness monitoring and fire drills. The registered manager told us all staff had access to a portal on the computerised IT system; this enabled them to access policies and procedures, to complete training courses and to receive emails.

The registered manager had a good understanding of their requirements of the Health and Social Care Act 2008 and the regulations. They had ensured appropriate and timely notifications had been submitted to CQC. Following the last inspection the registered manager had developed a comprehensive action plan which included 26 action points to address all the shortfalls identified within the inspection report. This had been revised in October 2015 and January 2016 and records showed the majority of points had been addressed.

There were systems in place to assess and monitor aspects of the quality of the service provided. We saw a corporate audit programme was in place and regular audits were carried out for areas such as: records and documents, handover, security and safety, healthcare records, staffing, people's personal finances, medication and cleanliness and infection. The registered manager confirmed the organisation had recognised the need to put in place a more appropriate audit programme for their care services and this was currently being developed. The organisation had developed new policies and procedures for the care services which had been implemented in November 2015. The registered manager confirmed a monthly operational report was produced for the senior management team which covered staffing and human resources issues, audits and quality and external stakeholder relationships. However, records showed shortfalls in staffing levels, supervision had not taken place in accordance with the organisation's policy and procedure and we found the principles of MCA had not been applied consistently and lawfully.

Records showed all incidents and accidents were monitored at service level and detailed incident summary reports were now produced which provided information on times of incidents, restraint duration, staff injury and an analysis 'trend line' for each person. The registered manager confirmed this information was now included and reviewed in the registered provider's clinical governance programme and that service staff attended the monthly governance and health and safety meetings. Senior management from the organisation attended the service regularly.

The registered manager told us the meetings for people who used the service had not been very successful and they were looking at alternative ways of gaining their views and recording them. The views of relatives were sought on a day- to-day basis or during care plan reviews. Annual surveys were issued by the organisation to all people who used the service, relatives and staff. We found the results for the relative's surveys weren't linked to specific services and discussed this with the registered manager who agreed that more specific surveys would be advantageous as this would provide clearer information and identify shortfalls more easily for each service. They confirmed they would pass this to the senior management team for review.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not always ensure that the Mental Capacity Act 2005 was implemented to protect the rights of people who lacked mental capacity. Some people were receiving care and interventions with no legal framework. Staff made some decisions without capacity assessment or best interest decisions. Regulation 11 (1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services did not always have sufficient numbers of staff available to meet their needs. Staff did not always receive on-going or periodic supervision. Staff did not always receive an appraisal of their performance. 18 (1) (2)(a)