The Regard Partnership Limited

Hazelwood House

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

Summary of findings

Overall summary

The inspection took place on 12 and 14 June 2018 and was unannounced. One inspector carried out the inspection on the first day and two inspectors on the second day.

Hazelwood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hazelwood House is a care service which provides accommodation for up to 11 people who have a learning disability or challenging behaviour. At the time of our inspection, there were 10 people living at the service. The service was arranged over three floors connected by three staircases. There were two bathrooms on the middle floor, a toilet on the ground floor, and a separate shower room at the rear of the building. There was a lounge, dining room and large garden that people could easily access. Most people were able to use the kitchen independently or with staff support if required.

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

The last comprehensive inspection of this service was in February 2016, when the service was rated Good. At this comprehensive inspection, we found the service was not meeting legal requirements and was rated Requires Improvement.

There were quality assurance systems in place based on a range of audits. However, we found these had not been effective in ensuring compliance with the regulations. We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Staffing levels were not sufficient to ensure that people received safe and person centred care at all times. There was no system in place to ensure staffing levels were assessed in consideration with people's individual needs.

The provider and registered manager had a lack of understanding around their responsibilities of protecting people's rights in line with the Mental Capacity Act 2005 and best interest decisions had not been completed appropriately.

People were not always able to access activities within the service or the local community in a way that was individual and person-centred.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people from abuse.

People received their medicines safely. Staff who administered medicines had received training and had their competency to administer medicines assessed to ensure their practice was safe.

Procedures were in place to learn from adverse incidents and there were appropriate systems to protect people from the risk of infection.

Effective recruitment procedures were in place. New staff received a robust induction to their roles and existing staff were competent, received regular training and were supported appropriately.

People were treated in a kind and caring manner. We observed positive interactions between people and staff.

The environment was supportive of people's needs. People's bedrooms were decorated to each individual's taste and contained personal possessions and photos.

People's care plans contained detailed and person-centred information and were updated regularly. Relatives and professionals were considered in people's care reviews.

Staff built positive relationships with people and their families. They used appropriate techniques to communicate effectively, promoted independence and involved people in decisions about their care.

People were encouraged to make decisions about how their care was provided, and staff supported people to be as independent as possible in their day to day lives.

Plans were in place to deal with foreseeable emergencies such as fire risk; staff we spoke with said they had had received training to manage such situations safely.

People were supported to maintain their health and well-being. Staff supported people to attend appointments with healthcare professionals. People were encouraged to eat healthily and staff made sure people had enough to eat and drink.

There was a complaints policy in place and people felt able to raise concerns.

There was an open and transparent culture. Visitors were welcomed and the registered manager sought and acted on feedback from people.

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.

There were not enough staff available to ensure people's safety at all times.

Appropriate recruitment procedures were in place and followed.

There were systems in place to protect people from the risk of infection. Individual and environmental risks to people were managed effectively. Staff knew what action to take in an emergency.

People said they felt safe and staff understood their safeguarding responsibilities.

Medicines were managed safely and people were supported to take their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to make decisions had not always been assessed in line with The Mental Capacity Act 2005. Best interest decisions and deprivation of liberty processes were not always followed appropriately.

People were supported to access health services and to attend appointments.

People had enough to eat and drink and were offered a choice at meal times.

People's needs were met by skilled staff who were supported appropriately in their roles.

The environment was supportive of people who lived there and people were involved in decisions around the decoration of the service.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion and we observed positive interactions between people and staff.

Staff protected people's privacy and encouraged people to maintain their independence.

People were involved in planning the care and support they received.

People were supported to maintain friendships and important relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always able to participate in activities within the service and local community.

Staff knew people well and demonstrated an in-depth knowledge of their individual needs.

Care plans contained detailed information and were reviewed regularly.

There was a complaints procedure in place and people felt able to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A quality assurance process was in place; however, this had not identified all the areas of concerns we found.

The provider did not always support the registered manager to enable them to manage the service effectively.

People and their relatives felt the home was good, and were asked for their views about the service by the registered manager.

There was an open culture within the home and staff told us they felt able to raise concerns.

All the policies were appropriate for the type of service.

Hazelwood House

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 14 June 2018 and was unannounced. It was completed by one inspector on the first day and two inspectors on the second day.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

We spoke with four people living at Hazelwood House. We also spoke with the registered manager and four care staff. We looked at care plans and associated records for four people, staff duty records, staff recruitment files for three staff, records of accidents and incidents, policies and procedures and quality assurance records. We also spent time observing the care and support people received in communal areas of the service.

Following the inspection, we received feedback from two relatives of people living at the service and two health care professionals who had regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

We received mixed opinions and feedback about the level of staffing and whether it was adequate to keep people safe and meet their needs. When we asked if people felt safe living at Hazelwood House one person told us, "Yes I do", A family member told us they felt their relative was safe and looked after well. They said, "There always seems to be enough staff." However, we identified there was not always sufficient numbers of staff available to keep people safe or to help ensure that a person-centred approach to care was being provided. For example, during the morning shifts, two staff were available to support the people living at the home. However, one member of staff would often have to leave the service to drive people to activities at a day resource centre. This left one member of staff to support the people that remained in the service, some of whom required regular monitoring due to behaviours that could place them or others at risk. The remaining staff member also had to provide personal care if required and support others where needed. We spoke with staff members about the levels of staff for each shift, who said, "Yes I do feel rushed. We have to do the cooking and cleaning as well" and, "It's horrible, its just manic." The level of staffing also meant that staff were not able to follow the provider's medicines procedure of having two staff present for all medication administration. We spoke to a staff member who told us that having two members of staff present to administer medicines 'didn't always happen.'

We discussed the staffing levels of the service with the registered manager and the provider's representative, who told us staffing levels were correct as the staff ratio was one staff member to five people. The registered manager said that the staff ratios of one to five had been in place for several years, however they were unable to provide the rationale for the current staffing levels at the service. The registered manager said they had 'the correct staffing levels for the budget.' There was not a systematic approach in place to determine the number of staff required to meet the needs of people and ensure their safety. People's needs had not been assessed to determine the level of support they required. Staff also told us that although they had told the registered manager and provider that more staff were needed particularly during certain times of the day, they were told that staffing levels were correct as there was one staff member to five people. Comments from staff included: "The ratio is a massive problem, it's not fair. [Registered manager] will come down if need be, but it's the main thing that gets everyone down" and, "The ratio is terrible here at the moment. There is so much pressure to get the staff hours right."

The failure to ensure there were a sufficient number of staff deployed to meet the needs of people's personal care and treatment, was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager sent us additional information about staff deployment. We reviewed this evidence and concluded that it did not alter our judgements around this issue.

Appropriate arrangements were in place to ensure that staff were suitable to be employed at the service. Staff recruitment records for three members of staff showed that the manager had operated thorough recruitment checks in line with their policies and procedures to keep people safe. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of

Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff files included application forms, records of interviews and references. On viewing these records, we saw that any gaps in a staff member's employment history had been investigated and outcomes were recorded. This meant that the registered manager could be assured that people employed at the service were suitable to work with vulnerable people.

The provider had effective systems and processes in place to protect people at risk of abuse and staff understood their safeguarding responsibilities. Staff had received training in safeguarding and knew how to identify, prevent and report abuse. They were confident that the resgistered manager would respond to any concerns they raised and knew how to contact external agencies for support if needed. We looked at records which showed the registered manager had notified CQC and the local safeguarding authority of all relevant safeguarding incidents and had completed prompt and thorough internal investigations where required.

Staff received appropriate training to be able to administer medicines to people safely. We saw records to show that staff were regularly observed administering medicines, as part of an ongoing supervision process to check their competency. There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines.

Medicine administration records (MARs) were completed correctly and accurately. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. MAR charts contained guidance sheets for staff on the management of specific medicines that had been prescribed for each person. The information included; what the medicine was for, the expected outcome of the medicine, the correct dosage and at what time the medicine should be given.

There were appropriate systems in place to protect people by the prevention and control of infection. All staff had attended infection control training and had access to personal protective equipment (PPE), which we saw they used when needed. All areas of the home were clean and systems were in place to check that all cleaning had been completed to a satisfactory standard. A health professional told us, "It's always clean and tidy when I've visited" and a family member said, "The cleanliness is lovely throughout the home, you never smell anything. It's done beautifully."

The registered manager had assessed the risks associated with providing care to each individual and this was reviewed regularly. Each person's care file contained specific risk assessments which identified the risks, along with actions taken to reduce the impact. For example, we saw a risk assessment for 'hot weather' in a person's care plan which stated, '[Person's name] could burn in hot weather if not supported to apply sun cream when going out in the sun.' 'Controls – staff to support [person's name] to apply sun cream and ensure they have plenty of it in hot weather.' Other risk assessments included: travelling in public places, shaving, seizures and managing personal care.

Environmental risks were also managed effectively. Gas and electrical appliances were serviced routinely. Fire safety systems were checked regularly and staff were clear about what to do in the event of a fire. We saw records of recent fire drills that had taken place and staff had been trained to administer first aid. In addition, each person had a personal emergency evacuation plan (PEEP), detailing the individual support they would need if the building had to be evacuated.

The service had an accident and incident reporting system in place. We reviewed records which showed that where accidents or incidents had occurred, there was a process in place to investigate and document these appropriately. We also saw where an incident had occurred at a day service involving a person living at

Hazelwood House, this was documented and explored thoroughly to help prevent any recurrence.

Requires Improvement

Is the service effective?

Our findings

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who 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 capacity to make particular decisions, any made on their behalf must be done so in their best interests and in the least restrictive way possible. The registered manager lacked understanding of their responsibilities to ensure that best interest decisions are made and recorded for people who have been assessed to lack capacity around decisions that restrict their freedom. For example, where bed rails were in place to prevent a person from falling from their bed, there was no information within the person's care files that showed what decision had been made, why it had been made or who had been consulted in the decision-making process. This meant that staff could be providing care and support unlawfully.

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 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. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant. However, this had not been completed in a timely manner and a delay had been caused, which meant that people may have been unlawfully restricted.

The failure to follow the requirements of the Mental Capacity Act 2005 and ensure care and support were only provided with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For day to day decisions and personal care, people's consent and preferences were considered by staff. For example we heard a staff member asking a person, "Are you ready? Are you happy for me to help get you up this morning?" People were not rushed to make a decisions and staff took time to let people communicate what they wanted.

People were supported to access appropriate healthcare services when required. Their records showed that they had regular appointments with health professionals, such as chiropodists, opticians, audiologists and GPs. Additional healthcare support had been requested by staff when required. For example, we saw that where there had been changes in people's behaviours, contact had been made with a community learning disability nurse to monitor their change in needs and review their medication. We spoke to health professionals who confirmed that where a referral was required, it was made in a timely and appropriate manner. They said, "[registered manager] is on the ball, she knows who to contact if there is an issue" and, "Suggestions have been given by us and they are taken on board." Appointments, visits, communication with health professionals and the outcomes, were recorded in detail. Staff knew people's health needs well and information in relation to people's health needs and how these should be managed, was clearly documented within people's care files.

Staff took the time to understand people's specific health needs, and the impact this had on their day to day lives. For example, one person had been diagnosed with early on-set dementia and staff had worked with the person to help them stay independent through the use of dementia friendly items, such as a large display clock. A staff member said, "There are some lovely things going on with [person's name], his keyworker is working hard to help him." Another person had a positive behavioural management plan in place, which detailed planned outcomes and 'how to reduce possible triggers' of their health condition.

Mealtimes were a social event. People were not rushed and were offered different choices in a timely manner. For example, on the first day on the inspection, we heard staff asking people what they wanted for lunch later that day, giving them enough time to choose. We saw people eating different options of hot and cold food at lunchtime, such as soup and sandwiches. Drinks were offered to people regularly and we saw jugs of squash and spare cups in the communal lounge. For each evening meal, a different person chose what would be cooked for each day, however staff told us that if someone did not like what another person had chosen, they could have something else. People confirmed they were offered a choice at mealtimes and enjoyed the food provided, they said, "I get to choose what I want to eat always." The service used a 'meal ideas' folder which contained pictures of different meals and foods, which staff used to help people decide what they wanted when it was their day to choose the evening meal. The folder also contained a list of people's favourite meals and recipes. For example, we saw a recipe for banana bread, which one person liked to bake when they received one to one support.

Staff were aware of people's nutritional needs and what actions they needed to take to ensure people's daily diet and weight were maintained at a healthy level. For example, we identified one person who had a diagnosis of diabetes, which was being controlled by their diet and medication. The person's care plan stated, 'I need to follow a low fat diet at all times due to weight issues / diabetes diagnosis. Ensure my meals are low fat. Staff to ensure they attend relevant training regarding my condition.' Staff confirmed how they managed the person's nutritional needs, they said, "We use low fat options and we try to bulk [person's name] plate with good things like vegetables." We also identified where a person had lost weight, a speech and language therapist (SALT) had been contacted and the person had been referred to the GP for various tests to establish the cause of the weight loss.

People's needs were met by staff who were suitably trained, skilled and competent. One family member said, "The staff are good, if there are any problems, they will notice." Another family member told us that they thought all of the staff were 'hard workers'. New staff completed an effective induction into their role. This included time spent shadowing (working alongside experienced staff), until they felt confident they could meet people's needs. Staff who did not have a vocational qualification were required to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Experienced staff received regular training in all key subjects, such as safeguarding, moving and handling and the Mental Capacity Act, and were supported to gain additional vocational qualifications which were relevant to their role. For example, staff told us about training they had received for a specific condition that one of the people living at the service had been diagnosed with. They told us the training was 'really good' and helped them to understand the complexity of the condition and the changing needs the person was experiencing. Another staff member told us they were booked onto a Makaton course, which is a form of signing and symbolic communication used by people with learning difficulties.

Staff told us they felt supported and valued in their role. Staff confirmed they received regular one-to-one sessions of supervision and a yearly appraisal with the registered manager or a senior staff member. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. Staff said they felt able to approach the registered manager if they had any concerns or

suggestions for the improvement of the service. One staff member said, "I'm able to talk to the manager at anytime. I'm confident that they would act if I raised a concern, definitely." Another staff member said, "[Registered manager] is really good. You can go to her and talk about anything."

The environment was well maintained and the structure of the service was supportive of people's needs. A health professional told us, "Generally, it's a quiet and peaceful place. It's a nice environment" and a family member said, "Oh, it's a brilliant building, [relative's name] see's it as his home." People's bedrooms were decorated to individual taste and contained personal items, photos and posters to reflect people's interests. People were able to choose how their bedroom was decorated, such as the colour of the walls and whether they wanted a hard floor or carpet. The registered manager told us any changes to the environment were discussed in monthly house meetings and people were given the chance to be involved in decoration decisions of communal areas. People were able to move freely around the home and could choose from a number of different areas to spend their time. This meant that people were able to spend time alone or with others in an environment of their choosing.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. People spoke positively about the staff and told us they were looked after well. One person said, "Oh yes, they do. They look after me and I get supported." A relative of a person living at the service told us, "The carers, they really do care."

Without exception, all interactions we observed between people and staff members were positive and supportive. Staff spoke with people in a polite and engaging manner. For example, we observed a staff member enter a communal area of the service where two people were watching the television. The staff member asked the people, "Would you like me to change the channel?" There was a discussion about what else was on and people jointly agreed on what programme to watch. On another occasion when a staff member was administering medicine to a person with a glass of water, they said, "Is this the cup you would like us to use?". This showed consideration for the person and their possessions .The staff member gave the person their medicine and took the time to have a conversation with them afterwards about their day.

Staff had developed caring and positive relationships with people and knew what mattered to each person on an individual level. For example, whilst sat in a communal area of the home, we observed a discussion between a staff member and a person about taking the person to get a father's day gift. The staff member clearly knew the person and their family member and talked about what they thought they would like. On another occasion, we overheard a staff member providing personal care in a person's bedroom. Throughout this time, we heard the staff member pointing out and talking about possessions and posters around the person's bedroom, which initiated a conversation they were interested in whilst they received personal care.

Where possible, people were encouraged to make decisions about their day to day lives, such as the activities and events they wanted to participate in. One person told us about an upcoming birthday party, which they had chosen to have in the garden of the service. The person indicated that they had been fully involved in making decisions about the party and who would be attending.

All people living at the service were encouraged to maintain their independence and the skills they already had. For example, on the first day of the inspection we saw people cleaning their bedrooms and helping with cleaning tasks in other areas of the home. Staff told us they encouraged people to be independent in their daily routines. One staff member said, "I prompt [person's name] to get their bath stuff ready, they are capable of doing it themselves. I encourage them to wash and dress themselves."

Staff protected people's dignity at all times. We saw they knocked on people's bedroom doors and waited for responses before entering. Staff described the practical steps they took to protect people's modesty when providing personal care. This included ensuring doors and blinds were closed, and making sure people were covered.

People's cultural and diversity needs were explored during admission assessments and ongoing development of their care plans. All religious and cultural needs were documented and 'cultural guidelines'

had been formulated in people's care plans which stated preferences such as people's religion, eating choices, clothing stipulations and celebrated holidays. Other parts of people's care plans gave further details about how they wished to express their religion or culture in their day to day lives. For example, one person's care plan stated they liked to go to church every Sunday, however they had recently stopped doing this due to a change in behaviour caused by early onset dementia. Instead, the person was supported to achieve their religious preferences by other means within the service, such as listening to CDs and watching certain television programmes.

We discussed the use of advocacy services with the registered manager. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. The registered manager was aware of how to contact advocates if needed, and told us about when one person living at Hazelwood House had needed to use an advocate when there was a possibility of them requiring a major surgical procedure.

Confidential information, such as care records, were kept securely and could only be accessed by those authorised to view them.

Requires Improvement

Is the service responsive?

Our findings

Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. A note in the front of each person's care plan reminded staff of their level of independence in each area of their care and daily routine. For example, one person's care plan stated, '[Person's name] is able to decide for themselves what they would like to do in their spare time.' A family member also told us, "[The staff] are very understanding if [relative's name] doesn't want to be involved with whatever is going on. He is able to stay in his room if he wants."

However, we also identified that people's choices were restricted due to the amount of staff available at times. This meant that people did not always receive the support they needed when making certain choices. For example, one person had a kitchenette in their room, where they were able to prepare their own drinks and snacks independently, however a staff member told us that the person, who is able to access the community independently, "wanted me to go with him to get new tea and coffee pots. I had to get it in my own time, there is no chance I could get it on shift." Other staff confirmed that people were not always able to choose their own personal items at the shops, such as toiletries, due to the fact that staff were not able to take people out of the service on a one to one basis.

Some people attended day services every week, where they enjoyed a range of activities such as gardening, singing and volunteering. One person told us, "I love singing. I go singing with [staff member] every Tuesday." However, where people were not able to attend day services, people were not always given the opportunity to participate in activities and entertainment within the home and in the local community. For example, we saw an activities plan for the home which showed that people were scheduled to go out for a social evening one day a week, however staff confirmed this was not always possible due to the staffing levels of one staff member to five people. We spoke with a family member who told us, "That's the only thing, I wish there was more involvement and someone who [relative's name] could do the gardening with." One person had recently moved out of Hazelwood House to a different service. As a result of this, a staff member was moved to work in one of the provider's other services. The registered manager told us that this was so that the provider's agreed ratio of staffing was maintained. Staff told us this had a direct impact on people's ability to access the community, one staff member said, "We used to go for lunch when [person's name] was here, everyone used to love going out." Another staff member said, "There isn't enough activities since [person's name] has gone. We used to go out all the time. [persons name] turned round to me the other day and asked to go out."

The failure to deliver care and treatment that is designed with a view to achieve people's preferences and ensure their needs are met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People were supported to maintain their important relationships. For example, one person had recently left the service and moved to another location run by the provider. Staff recognised that the person had developed a close relationship with another person, who remained living at the service, and had arranged for them to meet for lunch every fortnight, so they could maintain their relationship. Relatives confirmed

they were able to visit their loved ones at any time and were always welcomed by staff.

Each person had a care plan which contained individual information about their specific needs and how they wished for them to be met. This included key information about people's preferred daily routines, such as how they liked to relax and how they liked to prepare for a bath. Care plans contained a 'one page profile' which focused positively on people as individuals, such as, 'what people like and admire about me' and 'what is important to me'. Care plans contained detailed guidance of how to support people in a personalised and effective way. For example, one person's care plan stated, 'I am very unsteady on my feet and like to link arms with staff when I'm out.' Another person who required support with continence needs, had a care plan which stated, 'after using the toilet staff need to prompt me to wash my hands, I don't like doing this, staff sometimes do it with me.' Key information about people's likes, dislikes and preferences in their day to day routines had also been documented in an 'easy read' format, so that people could understand and comment on what was in their care plans in a way they understood.

Where required, clear information was in place for behaviour management. The guidance provided step by step actions to be taken when supporting the person during certain tasks or scenarios, such as 'communicating with [person's name] about household tasks.' There was also a clear explanation as to why the person may be experiencing certain behaviours depending on the circumstance, in order for staff to understand the person's needs. In addition, some people received one to one support at certain times of the day. We saw that in one person's care plan there was specific guidance around how best to support the person when providing one to one support.

Staff were organised and communicated effectively between themselves to ensure people's current needs were known and met. This was supported by daily handover meetings between shifts and regular staff meetings. Information provided to staff included details about people's emotional and physical health needs and meant that staff worked together to ensure that people's ongoing needs were met. Staff confirmed that they always had enough information at the start of their shift. They said, "I will always know who's going to be where and what they're doing, I could have a day off and still know." It was clear that staff were able to recognise changes in people as they occurred and were committed to delivering the best care possible.

Care and support was planned and in partnership with the people using the service, their family members and healthcare professionals where appropriate. Assessments were completed before each person moved into the home to ensure their needs could be appropriately met. Reviews of care plans took place regularly and where people were able to, they confirmed with us that they were involved in care plans and knew what was in them. People were supported by an allocated key worker to review their care plans and they had signed to say that they were happy with the content. Care plans also contained a staff signature sheet to confirm that each staff member had read and understood each person's care plan. Families told us that they were fully involved in the development and reviews of care plans and kept up to date about changes in their loved ones' wellbeing. A family member said, "I'm always told if [relative's name] is unwell." Another said, "Yes, I always get invited to the reviews."

A complaints procedure was in place and was displayed on a notice board in the reception area of the service. The registered manager had also produced the complaints procedure in an 'easy read' format with pictorial aids, for people who struggled to read standard sized print. We saw records of a complaint that had been raised internally by one person about another person living at the service. The registered manager had dealt with the complaint appropriately and had written an 'easy read' letter to the person in response.

Although the service is for people with learning disabilities and who are not elderly, we found that people's

care plans contained specific information that considered their end of life wishes. For example, people's favourite music to be played, their favourite colour, how they wished their body to be cared for and who they wanted to be involved. This meant that the registered manager and staff team were aware of what people wanted at the end of their lives. We discussed this with the registered manager who recognised their responsibilities around end of life care and the important discussions that needed to be raised with people and their families.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place to assess, monitor and improve the service. However, these were not always effective and had not identified the concerns we found during the inspection. The quality assurance process consisted of a range of audits, together with monitoring visits by a representative of the provider, however there was no system in place to
assess the adequacy of staffing in relation to people's changing needs. Consequently this had a direct impact on people's ability to receive personalised care and support within the service and in the local community.

We identified a failure to ensure people's rights were protected in line with the Mental Capacity Act 2005 and that best interest decisions were completed and recorded appropriately. This put people at risk of being unlawfully restricted when receiving personal care and support.

The service had failed to identify and ensure that people received care and support in a way that met their preferences and needs.

The failure to operate effective systems to assess, monitor and improve the service, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other quality assurance systems in place were effective. The manager carried out regular audits which included, health and safety and medicines management. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. Other formal quality assurance systems were in place, including seeking the views of people and their families about the service that they received. Where issues or concerns were identified, an action plan was created and documented.

People, family members, staff and professionals all described the daily management of the service as well-led. A health care professional told us, "[registered manager] knows her people, yes she is a good leader." A staff member told us, "[registered manager] is amazing, very supportive. I do think she doesn't want to upset anyone sometimes, but things are resolved well." The registered manager told us they were rostered to complete regular shifts alongside other staff and staff members confirmed the visibility of the registered manager within the service. They told us, "[registered manager] will always step in" and, "If I phone [registered manager], she'll be up here. She'd be up here like a shot, she goes above and beyond. It's a 24 / 7 job for her."

From our observations and speaking to staff, we identified that there was not always suitable support in place from the provider of the service. We were concerned about the levels of staffing and the provider's dependency on their 'staffing ratios'. This had not been fully analysed or monitored by the provider in order to ensure that people were safe and cared for in a person-centred manner. The registered manager spoke with us about the regular support they received from the provider's representative, but also expressed the pressure they felt to ensure staffing levels were 'within budget'. A staff member commented, "[registered

manager] get's good support, but sometimes it feels like you're banging your head against a wall."

We discussed the vision and values of the service with the registered manager, who said, "I want the service users to be happy, to achieve their goals, I want it to be right for them. We are like a big family here really." All the people we spoke to described an open and transparent culture within the home. Relatives were welcome to visit at any time and, people were able to have private space to talk confidentially. A health professional told us, "Yes there is always space to talk privately. We usually go to the office or dining room, or I will go to the person's bedroom with their permission." The main reception area of the service had a number of bright and colourful welcome displays, with pictures of all people living at Hazelwood House, as well as all staff members who worked there.

When people received difficult or significant news, the staff worked with people to support them to understand and communicated this to them in a way that they could understand. For example, the registered manager told us about the use of 'social stories' to help a person understand the impact of a family member having a terminal illness.

People were consulted in a range of ways about the way the service was run. These included regular house meetings, yearly questionnaire surveys and individual discussions with people and their relatives. People were supported by their keyworker to complete a 'my opinion survey' and we saw records which evidenced that people's views had been sought and action had been taken when issues were raised.

Staff spoke enthusiastically about their work and told us they enjoyed supporting people to enhance their lives. A staff member said, "I love it, we are very lucky here. The people here are settled, fun loving, we are spoilt in the job we have." Despite the lack of safe staff levels, staff told us they worked well as a team, and would recommend working at Hazelwood House to a friend. One staff member said, "I would say we are a pretty good team. The staffing isn't ideal, we are aware it isn't, but it's a lovely place to work – everyone gets on" Another staff member said, "Yes, I would recommend working here to a friend. [staff member] is my best friend, she helped me get an interview here."

All policies used by the service were stored online, such as whistleblowing, medicines administration and complaints, which staff were able to access. The registered manager also had a system to track policies and ensure staff had signed to confirm they had read through any new policies in place, or any updates to existing policies. The service had an 'emergency contingency plan' in place, which detailed various procedures to be implemented in the event of an emergency. This included details of a nearby care service which could be used for assistance and accommodation, and a list of people's essential medicines.

The provider notified CQC of all significant events and the service's previous inspection rating was displayed within the entrance of the home and on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to deliver care and treatment that is designed to achieve people's preferences and ensure their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to follow the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy a sufficient number of staff to ensure they can meet people's care and treatment needs.