Harrison Care Enterprises Limited

Powys House Residential Home

Inspection report

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Date of inspection visit:
23 February 2016

Date of publication:
05 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 February 2016 and was unannounced. The home provides accommodation for up to 18 people with a learning disability, mental health needs or dementia care needs. There were 17 people living at the home when we visited. The home consisted of three floors connected by staircases with a central lift to all floors. There was also a basement which contained the kitchen, laundry room, offices and a staff room. There was a good choice of communal spaces where people are able to socialise, and most bedrooms had en-suite facilities.

A registered manager was not in place at the time of the inspection, although the manager had applied to be registered with CQC and their application was being processed. 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.

Staff did not always respond promptly and consistently to people's needs. Care plans were not always up to date or did not support the delivery of personalised care. A new care planning system was being introduced but had not been completed.

People were satisfied with the care and support they received from staff, who were knowledgeable about their physical and personal care needs. However, staff did not always demonstrate a good understanding of how to support people's mental health needs. They had not been trained to communicate with people who had limited verbal communication and they did not have access to non-verbal prompts, such as pictures or symbols.

Staff did not always follow legislation designed to protect people's rights, so were unable to demonstrate that they always acted in the best interests of people.

Whilst most people received a nutritious diet, people were not always able to make choices about the food they received and alternatives were not always offered. The manager described the way meals were served as "institutional" and was taking steps to make it more centred on people's individual needs.

The provider did not have a clear vision or a set of values for staff to follow. A comprehensive auditing system was in place, although the manager recognised that this was not fully embedded in practice and was taking steps to improve it.

We observed positive interactions between people and staff and staff clearly knew people well. People were supported to build and maintain caring relationships. Their privacy and dignity were protected at all times and they were involved in planning their care.

People felt the home was run well. Management supported staff in their work and were described as

"approachable" and "supportive". Staff who understood their roles, were motivated, and worked well as a team. There was an open culture where visitors were welcomed and links with the community had been developed.

People told us they felt safe at the home. Staff knew how to identify, prevent and report abuse, and the provider responded appropriately to allegations of abuse. Where necessary, risk assessments and behavioural support plans were put in place to help protect people from harm.

Staff minimised risks to people without compromising their independence. Where people were not able to recognise or manage risks themselves, staff supported them appropriately.

Staffing levels had recently increased during the day and people told us there were enough staff to meet their needs. The process used to recruit staff helped make sure that only suitable staff were employed. Clear systems were in place for managing medicines and people received their medicines when they needed them.

Environmental risks were managed safely and a suitable system was in place to assess and analyse accidents and incidents across the home. There were arrangements in place to keep people safe in an emergency and fire safety equipment was checked regularly.

People had access to a range of activities, although their ability to take part varied greatly and the activities they had completed were not always recorded. They were supported to access healthcare services when needed and staff had good working relationships with other professionals.

The provider sought and acted on feedback from people. A complaints procedure was in place, although this was not provided in an accessible format for people.

We identified 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Individual risks to people were managed effectively. Staff knew how to identify, prevent and report abuse.

Suitable arrangements were in place to manage medicines safely. They were enough staff to meet people's essential needs and recruitment practices were safe.

Appropriate emergency arrangements were in place and information was available to support people if they had to be evacuated.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights and ensure they acted with people's consent.

Staff did not always demonstrate an understanding of people's mental health needs and had not been trained in the use of non-verbal methods of communication.

People's nutritional and hydration needs were met, although limited food and drink choices were available to some people and they were not always offered alternatives.

People had access to healthcare services and staff enjoyed good working relationships with healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

The culture of the mealtime experience was not centred on people's individual needs and did not promote independence or choice.

Staff interacted positively with people and built caring relationships with them.

People's privacy was protected and they were treated with dignity and respect.

People (or their families where appropriate) were involved in discussing and planning their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were not consistent in the way they responded to people's changing needs. Care plans were not always personalised or reflective of people's current needs.

People had access to a range of community and home-based activities, although these were not always recorded.

Feedback was sought and acted on. An appropriate complaints policy was in place and people knew how to raise a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have a vision or set of values for staff to follow. However, a development plan was in place to create a management structure and improve the service.

A quality assurance system was in place, although this was not always effective and needed time to become embedded in practice.

Staff understood their roles, were motivated, and worked well as a team.

There was an open culture and visitors were welcomed at any time.

Powys House Residential Home

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 23 February 2016 and was unannounced. It was conducted by two inspectors and a specialist advisor in the care of people with learning disabilities.

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 improvements they plan to make. We reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the home and two relatives. We also spoke with a director from the provider's company, the manager, an assistant manager, six care support staff, and a visiting social worker. Following the inspection we received feedback from a doctor who had regular contact with the home.

We looked at care plans and associated records for six people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

The home was last inspected on 14 January 2014, when we identified no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I feel safe living here. I have no worries about anyone or anything." They told us staff had responded well when they had complained about a person who had been upsetting other people and this was no longer a concern. A family member said, "My relative feels safe here; there's nothing that worries her."

Staff knew how to identify safeguarding concerns and acted on these to keep people safe. They had received appropriate training and were aware of people who were at particular risk of abuse. A care staff member told us, "I have had my safeguarding training. If I saw something I would confront and clarify the issue. If I felt I couldn't report to the senior or the manager I would go higher."

The manager conducted effective investigations into allegations of abuse. Following one incident, they identified that the service could no longer meet a person's mental health needs and were working with mental health commissioners to identify a more suitable placement for the person. In other cases, risk assessments and behavioural support plans were put in place to help protect people from harm. Some people looked after their own money and had locked cabinets to store this safely in their rooms. Other people's money was looked after by staff. A clear process was in place to account for its use; transactions were audited regularly and this helped protect people from the risk of financial abuse.

The manager told us staffing levels were based on people's support needs, in relation to events and activities that were planned for the day, and feedback from staff. They had recently increased staffing level from three to four staff in the daytime, as they had identified that three staff were not sufficient to meet people's needs. Two assistant managers were also about to be appointed, which the manager said would provide further support hours to people during the day.

People told us there were enough staff to meet their needs. One person said of the staff, "They're always there when I need them." We received mixed views from staff about the staffing levels. Whilst some staff felt they were adequate, some felt this was not always the case. One staff member told us there were enough staff, "as long as someone doesn't go sick", which they said happened "quite often". Another described the workload as "pretty full on". However, another staff member said, "The extra staff in the mornings has made a difference. It's not overly rushed and quite well paced. People don't have to wait [to be supported]." Two shifts were worked by staff. The day shift was from 8:00am until 9:00pm and the night shift was from 9:00pm until 8:00am.

Clear recruitment procedures were in place to help make sure staff were suitable to work with the people they supported. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home. The manager had introduced an additional process to help identify any gaps in the employment history of applicants. This prompted them to seek an explanation for any gaps, to check whether the applicant had suitable experience and that their conduct in previous care roles had been satisfactory.

There were suitable arrangements in place for the ordering, storage and disposal of medicines. These were safe and ensured records were made of medicines received and returned when no longer required. The service had recently changed their medicines supplier and staff told us the new arrangements were working well.

Medication administration records (MAR) showed people received their medicines as prescribed and when needed. They were checked before administration to ensure the correct medicine was given. Staff were assessed by the manager for their competency to administer medicines and received annual refresher training. When administration errors occurred, staff sought emergency medical advice and notified the duty manager. The member of staff was then re-trained and had their competency re-assessed. There was a daily audit of medicines and a weekly audit of MAR sheets and stocks of medicines in the home. This helped make sure that all medicines were properly accounted for.

Staff knew how to minimise risks to people without compromising their independence. For example, one person enjoyed working in the kitchen; staff encouraged this, but checked the person regularly to make sure they were working safely. Another person was at risk of falling, but liked to use the stairs independently. Their risk assessment identified that the person would be at increased risk if they carried anything while using the stairs, so required staff to monitor this and encourage the person not to carry anything on the stairs.

Where people were not able to recognise or manage risks themselves, staff supported them appropriately. For example, measures had been put in place to protect people at risk of developing pressure injuries. These included the use of special cushions and mattresses, together with careful monitoring of the condition of their skin.

Environmental risks were managed safely. Gas and electrical installations were checked regularly, as was equipment, such as hoists, to make sure they were working correctly. A hoist was used to support one person several times a day, and we saw instructions to remind staff how to use it safely were displayed prominently in the person's room. Windows in upper floor rooms had restrictors in place to prevent people falling and fire exits were alarmed, so staff would be alerted if people accessed fire escapes without staff support.

An appropriate system was in place to assess and analyse accidents and incidents across the home and learn lessons from them. For example, appropriate measures were put into place to protect a person with a history of self-harm. Thorough investigations were conducted to identify the cause of any injuries to people and action was taken to prevent a recurrence.

There were arrangements in place to keep people safe in an emergency. Fire safety equipment was checked regularly and scheduled improvements to the fire alarm system were planned to be completed in May 2016. Staff understood what action to take in the event of a fire, although fire drills were only held annually, which may not have been sufficient to ensure people and staff would be familiar with the procedures in an emergency situation. Personal emergency evacuation plans (PEEPS) were available for all people; they included details of the support each person would need if they had to be evacuated. Reciprocal arrangements were in place with a neighbouring home which could be used to shelter people in an emergency.

Requires Improvement

Is the service effective?

Our findings

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. Staff had received training in the MCA. Before providing care, they sought consent from people either verbally or by observing their body language. For example, a staff member told us about the signs a person displayed if they did not wish to receive personal care. They said, "If they [show these signs], we leave [the person] and try again later". Another person had entered into a voluntary agreement about the purchase and use of homely remedies. The agreement had been documented and was recorded in their care plan.

Where people lacked capacity, some best interest decisions had been made and documented, following consultation with family members and other professionals. For example, one person was being cared for in bed and a best interests decision had been made about the need for bed rails to be used. However, best interests decisions had not been made about other aspects of the care and support given to this person. This included decisions relating to the delivery of personal care and the administration of their medicines.

One person was being given their medicines covertly. Covert administration is when medicines are hidden in a person's food so they don't know they are taking them. A doctor had been consulted and had agreed that this was appropriate, but staff had not completed an assessment of the person's ability to make this decision or documented why it was in the person's best interests to receive their medicines in this way. The manager told us they were aware that "more best interests decisions needed to be made" for people and were in the process of addressing this in consultation with social care professionals.

Some people's ability to communicate verbally was very limited, but staff had not been trained to use non-verbal methods of communication; nor did they have access to communication prompts, such as pictures, to help them communicate with people and ensure people were giving valid consent to the care and support they received.

The failure to follow the Mental Capacity Act, 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager said they were developing consent forms for people who had capacity to make decisions to use. Following the inspection, they sent us a copy of a consent document they had introduced to help ensure that people's agreement to the care and support they received was properly recorded.

People were satisfied with the care and support they received from staff who were knowledgeable about their physical and personal care needs. One person told us, "I like living here." Another said, "The staff look after you"; and a family member told us their relative "seems quite happy here; she's settled in well." Responses to a survey completed by family members included the comment: "I am very pleased with the

care [my relative] is given. It puts my mind at rest knowing that she is happy and well looked after." One person had been cared for in bed for an extended period. A regime was in place for staff to turn the person regularly and maintain their skin in a healthy condition. A visiting doctor told us the lack of any pressure injuries during this time showed the regime had been effective.

Most people living at the home had a learning disability or mental health needs and some were also living with dementia. Most staff had received training in supporting people with mental health or dementia care needs; others had gained vocational qualifications in learning disabilities. However, the training had not been effective, as staff did not always demonstrate a good understanding of how to support people's mental health needs. For example, one person wished to go on a trip after lunch but expressed concern that they would not be able to complete a housekeeping job they were used to doing after each meal. The manager later told us the job was important to the person and they were "ritualistic" about the need to complete it. However, this did not appear to be recognised or understood by the staff member, who told the person that they would do the job for them, so as not to delay them going on the trip. This did not reassure the person, who became anxious and continued to express the need to complete the task. The staff member later told us the person had a "fixation" about the job and they were trying to "break the fixation" so it didn't stop them from going on trips. However, this approach had not been discussed with the person or agreed by the manager or mental health professionals as an appropriate strategy to support the person.

New staff received induction training, which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. They were assigned a 'buddy', who was a more experienced member of staff that they worked alongside until they were competent to work unsupervised. This process was supported by a 'buddy booklet' which helped make sure the training followed a structured process and was completed fully.

Training for experienced staff in subjects such as medicines administration, safeguarding, moving and handling was refreshed regularly. Staff told us they had received appropriate training to support people's personal care needs and keep them safe. One staff member said, "I have had a lot of training and tomorrow I am doing a course on the quality of life." Most staff had also obtained vocational qualifications relevant to their role or were working towards these.

Staff were appropriately supported in their work and received regular one-to-one supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. A staff member told us, "We talk about any issues and training needs; strengths and weaknesses; and any ideas to make the home better."

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). The provider had appropriate policies and procedures in place in relation to DoLS. Authorisations had been sought for six people and most staff were aware of the support these people needed to keep them safe and protect their rights.

Most people received a balanced and nutritious diet. The main meal of the day was served in the evening, with a lighter meal, such as sandwiches or pizza at lunchtime. People who went out for the day were given a packed lunch to take with them. A varied, four week menu was produced, which consisted of one main option at each meal with a choice of two side dishes. Some people told us they could choose an alternative if they did not like the main meal choice, although people with limited verbal communication would have struggled to do this.

People told us they liked the food, which was described as "Good" and "Alright". Staff had a good understanding of the foods each person liked and disliked and they were recorded in the kitchen and in people's care plans. We observed the lunchtime meal which consisted of sandwiches served from a trolley in the dining room. Some people were offered a limited choice of sandwiches and desserts. However, those who were unable to verbalise a preference were given food staff knew they liked without being offered a choice.

Another person was given a meal of tinned fish, which their relative later confirmed they usually liked. The person did not eat any of it and it was taken away. No alternative meal was suggested or offered, but five minutes later a staff member gave the person a bag of crisps, which they encouraged the person to eat. The relative of the person told us the person was a "fussy eater", but said they may well have eaten sandwiches if they had been offered as an alternative.

A further person had their meal pureed to make it easier for them to swallow and digest. Staff described how they did this, by blending all the food items together in a liquidiser. This was contrary to best practice guidance, which recommends presenting food items individually so the person is able to distinguish the flavour of each component of the meal.

A choice of drinks was available throughout the day, but only those people who could verbalise a preference were offered a choice. Others were given a drink that staff knew they liked. The amount people ate and drank was recorded for people who were at risk of malnutrition or dehydration. However, the amount people drank was not totalled at the end of each day, so it was not always easy for staff to assess whether people had drunk enough.

People were supported to access healthcare services when needed and they were seen regularly by doctors and healthcare specialists, including nurses from the community learning disability team, when needed. A visiting doctor told us staff at their practice had a good working relationship with the home and had "no concerns about the way [people] are looked after". A social care professional told us the key to working with staff at the home was "the relationship and trust" they had in each other.

Requires Improvement

Is the service caring?

Our findings

The culture of the lunchtime experience for people did not promote independence or support the delivery of personalised care and support. Staff stood behind a large trolley containing sandwiches and distributed food in a controlled way by calling up individual people or specific tables of people one at a time. Whilst people had an opportunity to discuss the menus in general, during 'house meetings', they were not supported to make choices on a day to day basis. When asked who chose the food each day, one person said, "The staff, I think" and another person said, "I don't choose my meals the staff do". When another person asked what was in the sandwiches, a staff member replied, "They're ham because you don't like cheese."

The meal was served at a set time each day and people took their seats at the tables up to half an hour before this. A staff member told us they didn't know why people arrived so early, but had not considered that people may have been indicating a preference to have their meals at an earlier time. While eating their meal, one person kept saying "Cold". The staff member in attendance said, "I know they're cold; you always eat them cold." A short while later, the staff member took the meal away without explanation or any communication with the person, which caused the person to shout "No".

The manager described the way meals were served as "institutional" and told us of plans to make the meal time experience more individualised for people. For example, they said they had already started to look at ways of encouraging people to make their own drinks rather than wait for the drinks trolley to arrive. They recognised that this needed to be done carefully and in consultation with people, as many of them had grown used to the culture and might not respond positively if changes were introduced too quickly.

People's ability to lead independent lives varied greatly. Some were able to access the community without support and made their own appointments to visit doctors, whilst some needed staff support to do this. Some people could communicate well verbally, whilst the verbal skills of other people were limited to single word responses. Information was available in people's care plans to help staff to communicate effectively with them. For example, the 'communication passport' in one person's care plan stated: "Use simple, short sentences; show a cup, for example, for tea. Ask questions that [the person] can respond to by saying 'yes' or 'no'. Remove distractions; talk slowly." We observed staff using these methods to communicate with the person. A staff member told us "Where people cannot communicate [verbally] we understand how they say yes or no and if they are happy or sad. We also know what they want." However, staff did not use any other forms of communication to support people to communicate, such as signs, pictures, prompts or items of reference. This compromised the independence of some people and their ability to make choices.

The interactions we observed between people and staff were positive and people told us staff knew them very well. One person said "I have been living here for 18 years and my care worker has been here for the same amount of time. I really like her and she knows me so well." Another told us "Staff are pretty good here. [They] are really friendly; they call me by my preferred name."
When medicines were being given, staff checked people were happy to receive them and explained what they were for. Care plans contained information about people's backgrounds and family history. Staff used

this knowledge to help build positive relationships with people.

Staff supported people to build and maintain positive relationships with people important to them. One person told us, "I can use the phone to speak to my sister." Another person had developed a 'positivity book' with their nominated support worker. This detailed people they could trust and positive phrases to help them remain in a good frame of mind. Several people had formed close relationships with others living in the home. Staff were aware of these and made arrangements for them to sit together at meal times, or engage in activities together.

People's privacy was protected by staff knocking and waiting for a response before entering people's rooms. When personal care was provided they ensured doors were closed and curtains pulled. People who were able to express a preference for a male or female care staff to support them with personal care had done so; their preferences were known to staff and respected, although they were not recorded in the person's care plan, so there was a risk this would not be followed consistently by all staff. When staff discussed people's care or offered to support people to go to the bathroom, they were discreet and ensured conversations could not be overheard. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. One person told us, "I do have a care plan downstairs. I don't know what's in it but I can ask to see it. I would talk to staff if I wanted to change it." Another person had developed a set of long-term goals with the support of staff and had signed their agreement to these in their care plan.

Family members told us they were always kept up to date with any changes to the health of their relatives. One had been involved in discussing arrangements for end of life care for their relative, to help make sure their wishes were met when the time arrived; their wishes had been recorded in the person's care plan. The manager told us of plans to introduce comprehensive six monthly reviews of people's care, which would involve the person, their family and other care professionals.

Staff did not rush when providing care. When people wished to self-mobilise around the home, staff encouraged them to travel slowly and at their own pace. When using equipment to support people to move, staff checked people were ready to move, gently reminded them to lift their feet up and made sure they were comfortable throughout the process. When people were sat in arm chairs, staff knelt down to engage with them at eye level and used touch appropriately to reassure them when they became anxious.

Requires Improvement

Is the service responsive?

Our findings

Staff did not always respond promptly to changes in people's needs. As part of the monthly review with their key worker the person had been asked: "Are you getting the support you require from the staff?" and "Is there always someone available when you need them?" For the previous three months, the person had answered "No" to each of these questions, but the reasons for this had not been explored or action taken to change or improve the support they received. The previous three reviews of the support given to another person identified the need for a picture-based activity planner to support the person with activities, but this had still not been developed. One person was known to become anxious after a visit by a family member. Clearly documented strategies were in place to support the person at these times, but staff were unable to confirm that these were always followed. A social care professional who had regular contact with the home told us people would benefit from "more consistency" in the way they were supported by staff.

The manager was in the process of implementing a new care planning format centred on the needs and wishes of each person. We viewed two care plans in the new format and found they were personalised and provided comprehensive information about how staff should support the person according to their individual needs and preferences. The majority of care plans were in an older format, contained limited information and did not always reflect the person's current needs. For example, the care plan for one person directed staff to support the person to use the commode every three hours, but staff told us the person was no longer able to use the commode. As the care plans were being changed this information had not been updated.

The recording of the support delivered by staff did not always confirm that people had received personalised care and support. For example, support people received with their continence was not always recorded; turning charts for a person being cared for in bed were only kept during the night; activity records were not fully completed. The manager told us this would be addressed as part of the roll-out of the new care plans.

The failure to ensure people always received personalised care, and their care plans reflected their current needs, was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Other people told us staff responded promptly, and understood and met their needs well. Each person had an allocated key worker. These were members of staff who were responsible for working with that individual and taking responsibility for making sure their needs were met. When asked what their key worker did, one person said, "Takes me shopping, buys me clothes and furniture, helps me sort my money, helps me tidy my room." Another person told us they could choose their key worker and if they wanted to change them they could. One of the key workers told us, "We have a monthly key worker review with people and talk about what has happened and what is needed to change things." Another said, "My key person wanted staff to just wash her hair and back as she had problems trying to do this herself. They then asked to try doing it again by themselves, but have now asked to go back to staff doing this for her." Staff were able to describe the signs a person showed when they experienced a relapse in their mental health. They were clear about the support that the person needed at these times and how it should be delivered, for example by using 'low-arousal'

techniques which helped the person stay calm; they also knew how and when to contact mental health professionals for further support.

One person was being cared for in bed. Their room was decorated in a theme of their choice and their TV was set to their preferred channel. Records showed they were receiving regular care and support, and were being supported to reposition every two hours. Bed rails were in place to stop them falling out of bed and their pressure relieving mattress was set at an appropriate setting for their weight.

Some people were empowered to make choices and have as much control and independence as possible. One person said, "I chose the decoration in my room and my furniture. I have my own ornaments and a TV and radio in my room." Another told us, "I choose when to get up, normally about 6:15am and go to bed when I want to."

People's ability to engage in activities varied considerably. Some people attended community based activities and social events, whilst others chose not to leave the home. One person said, "I go to the disco at [another care home] every week and really enjoy meeting friends." Another told us they liked helping in the kitchen, washed-up three times a week and managed their own laundry. A family member told us their relative was supported to attend a community club three days a week, but said there was "not much activity [for the person] in the home". Another person was trying to find an external computer course, because they said staff were not able to support them with this.

Activities were discussed with people and planned during house meetings. One person said, "We have a resident's meeting and talk about food and going out." We saw a plan of activities for the current week which included art, crafts, quizzes, music and games. Trips to local attractions or events were also planned, including exercise classes and social events. We observed staff spending time helping people with jigsaws and playing card games with them. A staff member told us, "People are choosing their holidays at the moment and some have said they want to go to [a holiday camp]." The manager told us they were planning to introduce 'activity planners' for people to help them choose activities more easily and to record all those they took part in.

Staff sought and acted on feedback from people during the key worker reviews and at house meetings. One person said, "Everyone is asked [about the food]. If everyone says it's horrible it comes off the menu, if it's just them they [have something else]." The provider also sought people's views through the use of questionnaire surveys. One person confirmed this and said, "I did a questionnaire with my key worker." The last survey questionnaire contained pictorial references to help people to complete them independently. The 2016 survey was in progress and the manager explained how the information obtained would be analysed and used to improve the service for people. Plans were also in place to change the monthly review process by introducing a format better suited to people's individual communication needs. The manager told us these would help facilitate further feedback from people.

Most people knew how to make a complaint. One person said they would "talk to the people in charge" and another said, "If I wanted to make a complaint about anything I would talk to a member of staff or the manager." The complaints procedure was available in the reception area of the home. However, this was only available in written format, so was not accessible to people who were unable to read. The manager told us of plans to develop a pictorial format of the complaints procedure, which would make it easier for people to understand the process. Records showed two complaints had been received in the past year; each had been dealt with promptly, in accordance with the provider's policy, and to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?

Our findings

The manager was new to the service and was going through the process of registering with CQC. They had already identified improvements that were needed and were creating a development plan to implement them. These included recruiting two assistant managers; making care plans more personalised; and improving the environment of the home to make it brighter and "less dated". The manager had been supported by an experienced manager from the provider's company and by other representatives of the provider who visited weekly. The manager told us the provider's representatives were "all contactable and supportive". The management structure was being developed and, when complete, would consist of a manager, two assistant managers and three senior support staff who had individual responsibilities.

The provider had not developed a clear vision for the service or a set of values for staff to follow. The manager told us they wanted to promote more life skills and independence for people and said they intended to develop this vision in the future and communicate it to staff during staff meetings and one-to-one supervisions.

Senior staff completed monthly audits of care plans. On reviewing these, the manager had identified that these, together with other checks conducted by staff, were not always effective as some repeated issues had not been addressed. For example, an audit form completed at the beginning of January 2016 identified information missing from one person's care plan, but six weeks later it had not been updated. The manager showed us an action plan they had developed to improve the quality assurance system further and help make sure that such issues were addressed promptly. Therefore, whilst the right structures were in place to manage the home effectively, these needed time to become embedded in practice.

The quality assurance system for other aspects of the service, including medicines, infection control and the environment were effective and conducted regularly. Where improvements were identified, actions were developed and tracked through to completion. The manager conducted a monthly analysis of 'behaviour charts' to identify any patterns or triggers for incidents that had caused people to become distressed. A training matrix was used to help ensure staff were up to date with essential training. A similar tool was used to monitor when safety checks, such as gas and electrical inspections were due. This quality assurance process had been effective in these areas. Records showed that during recent visits by the provider's representatives, they had dip-sampled care records; checked fire safety systems; spoken with people and checked staff understood certain policies.

People liked living at the home and felt it was well-led. One person said the management were "really good". A social care professional who had regular contact with the home told us it was "well-led and managed effectively" and when they brought anything to the management's attention it was "dealt with efficiently". They added that "improvements are already being made" by the new manager.

People benefitted from staff who understood their roles, were motivated, and worked well as a team. Comments from staff included: "The home is changing. The recent shift changes were for the benefit of people as they get more consistent care across the day"; "I like the new manager. I know I can speak to her";

"I absolutely love working [at Powys House]; we all work really well together. We have professional disagreements, but we come up with positive suggestions for the clients"; and "[The manager] is really good and really on the ball". Staff were organised and used handover meetings and a 'daily planner' to share information between them. One staff member told us, "We have a staff message book where we can leave updates on people for all staff to see."

Staff described the manager as "approachable" and said they felt able to "bring any concerns to them". The manager sought feedback from staff, including through staff meetings. They were encouraged to make suggestions about how the service could be improved. A staff member said, "We have a staff meeting regularly where we can review plans, bring up ideas and have a chat about clients." Another told us they had recently made suggestions to promote people's independence and involve them more in preparing meals. They said the manager had listened and was keen to take their ideas forward.

There was an open and transparent culture at the home. Communication between management and staff was relaxed and open. The manager had an open door policy and encouraged people and staff to discuss concerns. The provider notified CQC of all significant events; relatives could visit at any time and were made welcome. They had developed links with the community through families and friends; healthwatch; community clubs; attending local events; and involving faith groups.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Service users did not always received personalised care. Care plans were not always up to date or reflective of the current needs of service users. Regulation 9(1) & 9(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not follow the Mental Capacity Act and did not ensure service users were only provided with care and support with their consent. Regulation 11(1) &(3).