Support for Living Limited

Support for Living Limited - 246 Haymill Close

Inspection report

246 Haymill close
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Support for Living Limited - 246 Haymill Close is a care home providing personal care and accommodation to six people who have learning disabilities or autistic spectrum disorder The service can support up to seven people.

The care home accommodates people in one adapted building. The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The registered manager was working in line with the Mental capacity Act 2005.

However, we found some risks to people had not been mitigated when we inspected the service. This included, some potentially harmful items left unsecured in the garden and kitchen. Access to the building was not being monitored in a robust enough manner. This was because individuals from other units had access to the building without the knowledge of staff overseeing the home.

Generally, medicines were administered appropriately but we found the use of some medicines was not always stated. There was a concern therefore staff might not realise the importance of specific medicines.

The registered manager assessed staffing levels, but we found staff were at times too busy to spend time with people as people's support needs had increased significantly. We have made a recommendation to the provider to review staffing levels in line with national guidance.

Notwithstanding the above, relatives and professionals told us people seemed well cared for by staff who were kind and knew people well. Some people had been supported so well that incidents where they behaved in a way that challenged had reduced and their medicines had been reviewed and reduced to reflect that positive change.

Staff ensured people had access to health and social care professionals. Staff followed professionals' recommendations and guidelines. When necessary training was provided to manage people's changing health support needs.

Staff told us they received appropriate training and felt well supported by the management team. They

found the registered manager approachable as did people's relatives who felt they could raise a complaint or issue.

Staff communicated with people in a manner they could understand and were observed to be respectful and promoted people's dignity.

People were supported to attend activities that reflected their preferences and were supported to access the local community to meet friends and socialise.

The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

As part of thematic review, we carried out a survey with the registered manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people.

The service used some restrictive intervention practices in the form of medicines as a last resort, in a person-centred way, in line with positive behaviour support principles. The provider had worked successfully with their own behavioural support team and health care professionals to reduce the use of these medicines and incidents of behaviour that challenged the service had also reduced.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good on the 19 January 2017 (published 15 March 2017.)

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. The provider took immediate action to address the concerns we found during our inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Support for Living Limited - 246 Haymill Close

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector carried out this inspection

Service and service type
Support for Living Limited - 246 Haymill Close 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at all the information we have received about the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
People who use the service had complex needs and were not able to talk with us. We met with six people who used the service. We spoke with one relative about their experience of the care provided. We spoke with the area manager, registered manager, deputy manager, two care workers, the chef and the house keeper. We spoke with an activity worker from the providers day service where most of the people using the service attended sessions each week and an HR officer. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and four people's medicines records. A variety of records relating to the management of the service, including policies and procedures were reviewed. On the second day of inspection we visited the provider's head office and we looked at three staff files in relation to recruitment.

After the inspection
We telephoned and spoke with three relatives of people who used the service. We contacted three health and social care professionals and received feedback from two of them. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● There were some concerns identified during our inspection where safety monitoring was not robust. In the kitchen there were cleaning products in an unlocked cupboard under the sink. These included, dishwasher tablets and disinfecting fluid. There was no staff member present in the kitchen and there was a risk therefore people could have unsupervised access to potentially harmful products.

●There were some garden hazards. These included some uneven paving, old paint pots left outside an unsecured garden shed containing things to be disposed by the provider. These items could have been a hazard to people in the home and people from other services who had access to the garden area.

●The back garden had an unsecured connecting gate that gave access to the gardens of two other services managed by the provider. The back door to the home had also been left open to air the home. When care staff were upstairs supporting people, we observed a staff member from another unit and a trades person enter the care home on separate occasions via the garden gate and open the back door without the knowledge of the staff in the home. At the time two people who had complex needs were unsupervised on the ground floor. Therefore, people were not being protected against the risks that can arise when unauthorised people have access to the home. Any incident would not have been prevented by staff.

The above concerns are a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people's safety was being effectively managed. This placed people at risk of harm.

●We brought our concerns to the registered manager. After several attempts they were able to fasten the lock to the kitchen cupboard containing the cleaning products. The shed was made secure and the paint pots removed. The registered manager stated the back door to the unit would be kept locked when staff were not present, and a bell would be placed on the door to alert staff to visitors wishing to enter the building.

Staffing and recruitment

●Staffing need was assessed, and extra staff provided should a person require one to one support. However, we saw that the four care workers were very busy on the morning of our inspection. People living at the home had a high level of complex needs and this meant five people living in the service required two staff

each for personal care and all six people required one staff to either supervise or support them to eat breakfast.
●We observed two people got up late and did not have their breakfast until after 11.am. We asked staff about this and they told us those people liked to get up late sometimes. Whilst this may well have been the wishes of the people, there were no attempts to offer them breakfast in bed, since they would soon have lunch as about 1pm.There was a period of about 30 minutes when care staff were busy getting people up and there was no one supervising the one person who was waiting in the lounge for something to take place. They had eaten their breakfast and had received personal care but were just sitting waiting for an activity to take place.
● Staff told us there were times when they felt the staffing numbers were too low and they had felt "stretched" as people had increasingly high needs. Their comments included, "Because we are lacking in staff. Rushed off our feet, difficult because it is two staff to one [person] apart from one person, and "I think there are enough staff but now, [Because of a person's changing needs] it is tight." Relatives told us there were enough staff. Their comments included, "Yes a lot of staff, there is a staff turnover, so I don't always know the staff but several I know very well," and "I've never felt there was a lack of staff."
●Staffing was as stated on the rota. There were four or a maximum of five care workers on duty in the morning. Some staff were working extra hours and were undertaking a 12-hour shift. The registered and deputy managers were covering both this home and the sister home next door. Both were proactive at being "hands on" at times during the day to support staff.

We recommend that the provider seek and implement national guidance in relation to staffing levels in learning disability services.

●The provider undertook safe recruitment processes. Staff completed an application form and attended interviews to determine their aptitude for the role. Successful applicants underwent checks of identity, right to work in the UK and criminal records checks. References were sought from past employers to verify employment details provided by the applicant.

Using medicines safely
● Medicines administration was mostly undertaken appropriately. However, medicines records did not always state what the purpose of some medicines were. We found one staff member was not able to tell us the use of the medicines they were administering. This meant that staff might not always recognise the importance of certain medicines for a person's health and the relevant side- effects so they could take appropriate action, such as informing the person's GP.
●Notwithstanding the above, people's medicines records were completed accurately. Two staff administered medicines with one of them counter signing to confirm the correct medicines had been given. Medicines were counted to ensure they tallied with records following each administration.
●There were clear guidelines for staff about how each medicine should be administered according to people's preferences and needs. This included good guidance for 'when required' medicines should be given by staff through a Percutaneous Endoscopic Gastrostomy (PEG). This is when a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.
●Medicines were stored appropriately. Temperatures were recorded daily, and action was taken to adjust the temperature when it was needed to store medicines safely. Medicines including controlled drugs were kept securely.

Preventing and controlling infection
● The home was clean and there was no malodours. Staff received infection control training and there were

procedures in place to reduce the risk of cross infection. These included the use of colour coded mops for bathrooms, bedrooms and kitchen. There were good infection control and food hygiene practices reminders displayed for staff in the laundry and kitchen.

●The kitchen had received a five-star rating in February 2017 from the food standard agency. This is the highest rating award for a good standard. Food was stored appropriately, opened foods were kept refrigerated and dated to indicate when they were opened. No foods seen were beyond their expiry date.

Systems and processes to safeguard people from the risk of abuse

● The registered manager had systems in place to recognise and report abuse. They monitored daily records and incident reports, spoke with staff and observed people living in the service. Complaints, incidents and accidents were entered on an electronic system and monitored by the provider to ensure safeguarding concerns were identified.

●Several relatives told us they felt their family member was safe. One relative said, "Yes I feel they are safe," and described, "There can be some challenging behaviour in the house [but] I have never seen anyone treated badly." Another relative told us, "Absolutely, [Safe]. [Person] has been there a long time, well cared for and well looked after."

●Staff had received safeguarding adults training and demonstrated they knew how to recognise and report safeguarding adult concerns appropriately. One staff member told us they would recognise if there was a concern by, "Knowing them for a long time, their mood, no smile if they don't appear to be happy or if they are losing weight, refusing food or drink. Anything unusual I would report it."

Learning lessons when things go wrong

●There had been a serious incident at the service. This was in the process of being investigated by commissioning bodies. The provider had undertaken their own investigation and had put in place measures from shortfalls they had identified, and the lessons learnt.

●The registered manager described they had reviewed procedures and risk assessments. They had put in place a robust risk assessment and met with the staff team to ensure the same concern would not reoccur. The area manager told us learning from the incident had been shared across the provider services.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The registered manager told us they would visit people to assess their support needs prior to offering a service. The provider had assessment tools to support senior staff to gather relevant information and ask person centred questions to determine people's preferences.
- People's care plans were reviewed on a regular basis, so they remained up to date and contained current information. All relatives except one told us they were invited to their family member's review and if they could not attend they were sent copies of the care plan.

Staff support: induction, training, skills and experience

- New staff completed an induction process to familiarise themselves with both the organisation and the home. Shadowing of experienced staff and training the provider identified as mandatory were provided. Staff completed a probationary period to establish whether they were competent to undertake their role.
- Staff told us they received training to undertake their work. One staff member said, "There is enough training, all training is mandatory. When it is being run we get a reminder from the people in HR…Certitude when it comes to training are very good."
- The training data base showed staff completed training that included, first aid, medicines, practical moving and handling, health and safety, food hygiene, epilepsy, resuscitation and choking. Most training was undertaken face to face with some e-learning. Staff were assessed to ensure competency prior to administering medicines. Most staff had received further training to support people receiving their nutrition and medicines through a PEG tube to ensure they could support people with a PEG safely.
- Staff received basic training about people with learning disabilities. They had a half day training in their induction. We were told this also covered people who were on the autistic spectrum.
- There was some information displayed about intensive interaction. This is a technique used to work with people who have profound learning disabilities. We could not see that training had been offered to staff, although a video clip was available should staff wish to view it. Following the inspection, the area manager told us staff were being offered training opportunities to attend intensive interaction training.

Supporting people to eat and drink enough to maintain a balanced diet

- People's care plans contained clear guidelines telling staff about their dietary requirements. Guidelines included how their food should be served and specified the texture such as soft or pureed. Plans also contained information about foods people did not like or foods to be avoided for good health. Dietary guidelines were also displayed in the kitchen for staff reference.

●When a speech and language therapist or hospital consultant had made changes to a person's dietary support, the reviewed care plan was shared with the staff in the "Read and sign" file. In addition, this was also included in the communication book before it was placed in their care plan folder. This was to help make sure all staff were aware of the changes and to avoid mistakes being made.
●We saw staff created a varied menu each week and placed picture menu cards on a white board in the dining room to let people know the next meal. People's likes, and dislikes were known by staff and if a meal was served and refused an alternative was offered.
● We observed that people were offered drinks throughout the day of our visit. A care worker told us, "Hydration is very important in their life. They like to drink, if they refuse there is an underlying issue. We offer drinks very often."

Adapting service, design, decoration to meet people's needs
● The service was adapted for people who had physical disabilities. The lounge and people's bedroom contained ceiling hoists to transfer people from their wheelchair, bed and comfortable chair in an appropriate manner. Bathrooms were in some instances en-suite and all contained adapted baths or shower equipment. Corridors were wide to accommodate wheelchairs with ease.
●There was a lift to support people who could not use the stairs to the upper floor. Some people were mobile, and corridors had hand rails fitted so they could mobilise safely. There was a large garden for people's use. The home was bright and airy and communal areas contained some objects of interest.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff supported people to have access to health and social care. We saw people had been supported to see the GP when they showed symptoms of being unwell. Referrals had been made to community health professionals including, district nurses, speech and language therapist, occupational therapists and advanced nurse practitioner.
●We spoke to a health care professional who confirmed staff were proactive in recognising and reporting concerns and followed their recommendations. They described the registered manager, was determined when, "Chasing up" anything on behalf of people.
●Some relatives described they were kept well informed by the staff team if there was a health concern. They told us, "If [Person] is in hospital I always get a phone call from a member of staff who is with them to let me know how they are…staff sit with them the whole day, I couldn't ask for anything more" and "Yes I get a phone call if there is a need to discuss something …[Person] health needs all have stopped, [gone] it might be down to the care and attention staff give but it is hard to be sure."
●People were supported to have routine health checks that included visits to the optician and dentist. People's oral health care regime was person centred and detailed in their care plans for staff guidance. When appropriate daily health records were kept, for example bowel movement charts. All people were weighed monthly to capture any weight loss or more often if a concern was identified. Staff had reported to the GP when people were found to have lost weight.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● The registered manager had made applications for DoLS in an appropriate manner on behalf of people living at the service. The applications have not been fully processed by the statutory body but the registered manager had liaised with the statutory body at intervals to ask for progress updates.
●The provider had arrangements that staff were familiar with to deal with cases where people could not give consent. The management team had recently contributed to a mental capacity assessment and best interest decision made with health professionals about the best course of action to support one individual who was unwell. The management team had supported a person who did not have family members to have an Independent Mental Capacity Advocate (IMCA). This is someone who can support a person who is not able to make certain decisions about their lives.
●Staff had received MCA training and demonstrated they understood their responsibilities to support people to make decisions in their everyday life when they could. Their comments included, "We give people choices, ask what food they would like, offer different cereal boxes, ask what they want to wear in terms of clothes, we show them, and they are able to show by body language very clearly. Some make their choice more briefly, but they are still able to show their decision."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question had remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Relatives told us that staff treated people in a caring way. One relative said, "I always look to see how staff treat other people and I have never been disappointed," and "Absolutely" staff are kind and caring. Another relative told us, "I do think the care is good, because the staff working there, the residents seem to trust them."
- Relatives told us there were staff who had worked at the home for a long time. They felt the consistency had helped their family members. One relative said, "Over time yes, a lot of staff faces I know, and they have been there for years. It helps [Person] and other clients. They get to know what the clients want."
- Some staff had worked with people for many years and spoke about them with warmth and feeling. They held a lot of knowledge about people and had shared their knowledge in care plans and advised newer staff. They told us, "You show you care, your way of communicating, you talk even though they don't answer back. You talk, and you see them listening. They can't respond verbally but they smile," and "A gentle approach and consistently…be there for them and be respectful."

Supporting people to express their views and be involved in making decisions about their care

- Most people using the service did not communicate their wishes verbally. Most relatives felt staff communicated and understood their family member well. Their comments included, "Yes they know [Person] better than I do!" and "Staff have remained always very attentive. They have worked out what it is [Person] is asking. A drink, food or attention."
- One relative thought staff could spend more time to talk with their family member. They felt whilst staff made sure the person was comfortable and were caring perhaps further work might be done to explore other ways of communicating with them. However, they did feel staff understood when the person was happy with something offered.
- We observed people making their choices known through behaviour, body language, facial expression and vocalisations. For example, one person chose their clothes for the following day. Clothes were shown by staff and approved by the person or not. Staff hung the clothes out for the person to see. The person indicated the clothes to us and was clearly pleased with their choice.
- People's care plans contained a 'Communication profile' about how they made their wishes known and how they understood information. The profiles were clearly written in an accessible manner. Guidance stated what it meant when a person did something such as a specific vocalisation or action and stated what they probably wanted to happen.

●Incidents of behaviour that challenged had reduced significantly. Staff felt this was because they had worked with professionals to understand people's support needs. This had resulted in the medicines to manage one person's behaviour had been reviewed and reduced. This indicated staff were recognising and meeting the person's needs and preferences.

Respecting and promoting people's privacy, dignity and independence

●Staff told us how they supported people to be more independent. They explained this was by supporting people to make choices about what they wanted to happen. One care worker described one person would take their shoes and stand by the door to indicate they wanted to go out. Staff would then support them to go for a walk or a drive.

●People who could were supported to eat independently. We observed one person eating sandwiches for breakfast. They were smiling and looking happy as they ate. The care worker explained the person could eat these independently without staff support.

●People were asked if they wanted their bedroom doors closed or open if they could indicate which they preferred. When being supported for personal care both the bedroom and bathroom doors were closed. We heard staff knock and announce who they were before entering the rooms.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People had person centred plans that contained a detailed history and stated their preferences and dislikes. Plans informed staff about important people in their lives, such as people's close relatives. Plans were reviewed on a regular basis. We saw when there had been changes to people's care plans because of a health concerns this was flagged up for staff to read and sign that they had read the revised care plan and understood what was required.

●Plans contained clear guidelines about people's daily support. There was personalised information to guide staff about what a good or a bad day looked like for the person. This gave a good indication about what had been found to be important to the person.

● Guidance for staff in care plans included information about moving and handling, personal care and support to eat. People's daily notes were also person centred, their mood, activities and important information was recorded.

●Information about people's diverse needs and support was recorded where appropriate. In most of the records reviewed people were not able to express or demonstrate their religious or cultural beliefs. Therefore, their family had been consulted about what they felt was important for the person. People sexuality support was considered, and relevant information was recorded in a respectful manner.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to undertake a variety of activities that were tailored to their individual preferences. They had one to one sessions with staff. For example, an outing using the home's transport into the local community or a massage therapy in their home. There were some group activities at the home that included music sessions, pampering and arts and crafts.

●People were supported to interact with each other during activities and meal times. This included celebrations such as birthdays, religious and cultural festivals. Most people had lived together in the home for many years and had been supported by staff who had known them for many years. People were visibly pleased to see some staff who they recognised and knew well.

●Staff described working with individuals to do what they enjoyed. One care worker told us, "[Person goes out every day, dependent on their mood…keeps them happy but sometimes doesn't want to go out. For a change we drive them to the park where there are not many people, they like this and [Person] loves to go on holiday."

●The home was situated close to the provider's activity centre. Some people attended and joined others in

group activities that included music therapy, sensory sessions and sports. Some people attended other community organised events for example a weekly singing event. One person who did not like attending the provider's centre was visited by the centre staff who provided someone to support the person on a one to one basis. The staff described they, "Had a chat and a banter" and sometimes took the person for a walk in the local area or garden.

End of life care and support

● People had end of life plans. Where possible their family had been consulted about what they would like to happen. Plans contained information about, funeral financial plans, funeral arrangements and how the person might be remembered for example by a head stone or a recording in a book of remembrance.

●The provider was actively working with relevant professionals to undertake a best interest decision for end of life care for a person who did not have family support.

●End of life plans alluded to if a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was needed. Plans reviewed did not contain a DNACPR as a decision was to be made in the event this was necessary. Staff had received resuscitation training as part of their first aid course. This was a mandatory part of their induction training.

●The registered manager told us that they were working with the GP and the palliative care team to support people when end of life care was required.

Improving care quality in response to complaints or concerns

●Complaints procedures were displayed in an easy read format and relatives told us they knew how to complain and felt their complaint would be answered. Their comments included, "If I had a problem I would go to the registered manager. I would flag it up to them and leave it in their hands," and "I feel I could raise an issue with [Registered manager]."

●We saw that a couple of complaints had been made and were being addressed. Complaints were made to the registered manager or to the person's social worker and the provider investigated. They logged and tracked complaints and scrutinised these to ensure they were not of a safeguarding adult's nature. Outcomes were recorded.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●The provider demonstrated a commitment to making information accessible. To facilitate this there was easy read information for people and visitors. This included people's care plan documents, service users guide, complaints procedure and fire procedures displayed in communal areas to follow in the event of a fire.

●The provider had arrangement to ensure information about people was handled appropriately. They had also placed a letter at the front of each person's care record explaining why information was recorded, who might have access to the information and how that information would be used.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Whilst the provider had comprehensive systems around quality assurance and risks management, we found that in a few cases these were not that effective. During the inspection we identified some risks to people's well-being that had not been identified or addressed. These included harmful items left unsecured in the garden and kitchen and access to the home not always being monitored to ensure only authorised people were allowed into the home.

●Notwithstanding the above there were daily checks of the environment taking place and some concerns seen at inspection such as damaged wall sockets and a faulty light on the fire panel had been fully reported to the landlord and "chased up" in a timely manner by the registered manager.

●There had been a recent environmental audit and there were action plans detailing what was to be undertaken. This included for example, archiving of confidential paperwork in line with the General Data Protection Regulation (GDPR). There were weekly checks that included, health and safety checks, fire alarms and medicines audits.

●We saw the registered manager undertook monthly audits that included reviewing all people's care records. They checked to ensure for example, care plans were up to date, hospital passports were current and daily notes were being written in an appropriate manner. The registered manager also undertook monthly medicines and health and safety audits.

●The area manager undertook a six-monthly audit that contained an action plan for completion by the registered manager. All the monthly and six-monthly audits were reviewed by the provider's quality team who compared compliance with other services and looked for trends and good practice across the all the provider services to ensure learning took place.

● The registered manager and the deputy were clear about their roles. They both also covered the adjacent home. Staff were familiar with the service. They took roles additional to their care worker role. This included shift leader when they took the lead and designated tasks to the other care workers to ensure all necessary duties were performed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●Relatives, professionals and staff told us the registered manager was approachable and they felt would address any concerns. One relative said, "They [Management team] are very good and always very open."

●Staff told us they received supervision on a regular basis and they found this helpful. They said they could speak with the registered manager or the management team when they wanted to. One care worker said, "If there was a problem I would go to [Registered manager] and talk. Yes, they would listen." There were monthly team meetings where information was shared and staff had an opportunity to raise their views about people's care and staff practice concerns.
●A health professional told us, "I have found them to be supportive...they don't make a decision on their own about care they check out professionals view for decisions first." This supported good outcomes for people.
●The provider's leadership team visited the care home at least once a year and this gave an opportunity for relatives to meet with them and raise any concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Both the registered manager and the area manager stated they felt it important to be open and transparent in addressing complaints and apologise when something had gone wrong. The registered manager had reported concerns to the local authority in an appropriate manner and had notified the CQC when there was a legal requirement to do so. The registered manager acted with candour as did the provider who investigated when there was a concern and shared the learning with the relevant professional bodies.
●Health professionals told us, they found the manager shared information when there was a concern. One professional told us, "Yes the manager has always tried to make [themselves] available when I visit, or [they] arrange for [their] deputy to be available. The manager is very approachable and friendly and appreciative of any input given. [They] proactively e-mail me if there are any concerns."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The provider, Certitude, had strong links with the local community and used their own resources for the benefit of people living at the service and others. Several people at the home had taken part in a project being facilitated by the provider's activity centre. The project had invited people with profound disabilities both inside and outside of Certitude to use a specially adapted bike called a Terra bike. This bike allowed people with disabilities to mobilise and strengthen their muscles and increased lung capacity. The aim is to purchase a bike for use by people with profound learning disabilities in the local community.

Continuous learning and improving care
● The provider was supporting both the deputy and registered manager to achieve their level five in Health and Social Care. They told us they also kept their learning updated through attending registered managers' forums provided by Certitude and by the local authority. They described these were good for sharing and learning from other managers' experience and discussing new trends in social care. The provider circulated a "Quality brief" to management teams to share with the wider staff team. This gave an opportunity to share good practice ideas and initiatives.
●The provider had introduced an electronic care planning system in June 2019 and provided training for both management team and care staff to use the system effectively. The new system was remotely accessible by the registered manager and deputy and allowed them to scrutinise the care being provided to people when they were not present in the home.

Working in partnership with others
●The management team worked in partnership with health and social care professionals to offer a good quality service for the benefit of people living at the home.

●They utilised specialist resources within the provider service. This included the intensive support team who advised and supported staff to meet people's more complex needs such as when they behaved in ways which challenged the service.

●In addition, the provider had practice leaders who had oversight and training in relevant fields to disseminate information to ensure services were working to the same standard. For example, one practice lead was attending the service soon to offer further support with medicines administration.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of the service users and do all that was reasonably practicable to mitigate any such risks. Regulation 12 (1)(2) (a) (b)