Autism Care UK (3) Limited

Alexandra Park

Inspection report

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07 December 2016
12 December 2016
15 December 2016
17 January 2017
18 January 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**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 7, 12, 15 December 2016 and 17 and 18 January 2017. Visits on 7 December 2016 and 17 January 2017 were unannounced. This meant that the provider and staff did not know we would be visiting.

Alexandra Park is registered to provide accommodation for up to 32 people with learning difficulties and mental health needs. It is comprised of 28 single occupancy bungalows and a four bedroomed house, located within extensive grounds. Support is provided over a 24 hour period by staff who are based in individual bungalows and managed from the on-site resource centre. The resource centre is also used for training, social activities and administration of the site.

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

The service was last inspected in August 2015 and at that time we rated the service as 'requires improvement' but it was found to be meeting all legal requirements.

During this inspection we found people had not been protected from the risk of abuse and improper treatment. We found entries within two people's care records which detailed safeguarding incidents. These records had been signed by a team leader but staff had not identified the improper treatment or informed the registered manager. During our inspection two safeguarding referrals were made to the local authority who are investigating the incidents.

Accidents were monitored and reviewed by the registered manager. Action had been taken to reduce the risk of them reoccurring.

People, relatives and our observations confirmed there were enough staff to meet people's needs. Records showed safe recruitment processes had been followed.

Staff had been trained to administer medicines and followed good practice. Before our inspection the provider had noted there had been an increase in medicine errors, but action had been taken to address this, staff were in the process of receiving additional training in this topic.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'.

The MCA had not always been followed. Some decisions had been made on people's behalf, however the

provider could not demonstrate how the person's capacity had been assessed or that they had considered the principles of MCA and 'best interests' in determining the decisions. Where capacity assessments had been undertaken these were often broad, and not decision-specific. People's care plans described their routines, and stated these plans were in people's best interests, but information had not been provided for staff about how to balance people's right to make choices with their planned routines.

Where people displayed behaviours which may challenge staff, such as anxiety or aggression, detailed care plans were in place to describe to staff how they should respond to people. However these had not always been followed. Staff had introduced new responses which were not based on an assessed need, care planned or evaluated. This meant people could be at risk of receiving inconsistent or inappropriate care.

Where restraint was practiced, additional recording was in place to monitor the use. We found two incidents where people had been restrained but these additional monitoring records had not been completed. On one of these occasions and non-approved method had been used.

Staff received training and supervision to ensure they had the skills and knowledge to meet people's needs.

People were involved in planning their meals and shopping for their food. External healthcare professionals were involved to ensure people's general health and well-being was maintained.

Whilst we found records which showed two people who used the service had not always been treated with dignity and respect, relatives we spoke with told us staff were kind and caring. We observed positive interactions between staff and people who used the service. People appeared relaxed and staff were knowledgeable about their needs.

People's independence had not always been promoted when restrictions had been put in place to maintain people's safety. Staff and relatives told us people were encouraged to be independent. Relatives told us they were included in planning people's care and that they were kept up to date with any changes to their relative's needs.

Care plans were varied. Some were very detailed and gave clear information for staff. Other decisions about people's care had not been communicated well to staff which meant people were at risk of inconsistent care.

Care records were large, it was difficult to know where specific documents were stored, and some documents were poorly completed. However they did contain personal information about people's needs and personal preferences.

The provider, registered manager and staff within Alexandra Park undertook a schedule of audits and quality checks. However this system was not effective and robust in monitoring the quality of the service provided. None of the shortfalls which we identified during this inspection had been highlighted by internal checks.

Since our last inspection the management structure had been reduced. The registered manager had taken on additional responsibilities for the provider organisation, and the support manager positions within Alexandra Park had been reduced from three to two.

Relatives and staff spoke highly about the management team. They told us the registered manager and support managers were making improvements within the service and were a visible presence.

People who used the service, relatives and staff had been asked for their feedback on how the service was run.

We have identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take 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?

Requires Improvement

The service was not always safe.

Record indicated that safeguarding incidents had occurred which had not been dealt with appropriately.

Systems around medicines had been improved since our last inspection.

There were enough staff to meet people's needs.

People's individual bungalows and the communal areas of Alexandra Park were clean and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2005 were not met.

Where people displayed behaviours which may challenge staff, support plans were not always followed. Incidents of behaviours which challenge had not been monitored to identify trends.

Detailed records were kept to monitor when restraint had been used, however we found records of two occasions restraint had been used where this documentation had not been completed.

Staff had been supported to develop the skills, knowledge and experience to provide care to meet the needs of the people who used the service.

People were supported to access health professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw a number of references which described where people had not been treated with respect.

During our observations the staff team displayed caring attitudes and positive interactions towards people. Relatives told us staff were warm and kind.

People and relatives were involved in the planning of care. Information had been provided in a way which met people's communication needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care people received had not always been planned, or based on their assessed needs.

People's care records were very long, and it was difficult to find out where important information was kept.

People's plans of care were varied, some were not complete, whilst others were detailed and clear.

People took part in a range of activities in the community and within Alexandra Park.

There was a complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

The system in place to monitor the quality and safety of the service had not identified the shortfalls that we identified during the inspection.

Relatives and staff were positive about the leadership at the service. They told us the registered manager was making improvements in how the service was run.

Alexandra Park

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 7, 12, 15 December 2016 and 17 and 18 January 2017 and was unannounced.

The inspection team consisted of an inspector, an inspection manager and a specialist advisor. Specialist advisors are clinicians and professionals who assist us with inspections. The specialist advisor on this inspection was a registered nurse with governance experience. Following the inspection we sought advice from one of CQC's National Mental Health Act Policy Advisors.

Prior to our inspection the provider submitted a Provider Information Return (PIR). A PIR 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 all of the information contained within the PIR and also statutory notifications the provider had submitted since our last visit. Statutory notifications are submitted to the Commission by registered persons in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. We used the information that we gathered and reviewed to inform the planning of this inspection. We contacted the local Healthwatch service, and spoke with commissioners from two local authorities and a clinical commissioning group, a local authority safeguarding team, and a member of the Positive Behaviour Support Team to gather views of professionals who come into regular contact with the service.

Not everyone who used the service was able to speak with us. We spoke directly with six people who used the service to obtain their views on the care and support they received. We were shown round some people's bungalows, with their permission, and were able to review their accommodation arrangements, including kitchens, bathrooms and living areas. We spoke with two relatives who were at Alexandra Park during the inspection and we contacted five relatives by telephone.

We spoke with the registered manager, an acting manager, two support managers, two team leaders and ten support workers. We reviewed a range of documents and records including; six people's care records in detail, an additional three people's daily care records, four records of staff employed at the home, complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings with people who used the service and a range of other quality audits and management records.

After the inspection we wrote to the provider. They sent us information to evidence that prompt action was being taken to address the inspection findings.

Requires Improvement

Is the service safe?

Our findings

During our inspection we reviewed nine people's daily care records. These are records kept by staff to detail the care and treatment people have received. Within two people's records we noted a number of entries made by staff which indicated that they could be at risk of abuse. Records detailed that people's rights had not been upheld and staff had not treated them with respect. One person's records described punitive measures which had been imposed. We immediately raised our concerns with the registered manager and ensured that a referral was sent to the local authority safeguarding team.

We saw from one person's daily care records that during an incident staff had described the use of a non-approved restraint technique. This had not been reported to the registered manager or been recorded within specific restraint records.

Staff told us and records showed that they had received training in safeguarding people from abuse and they demonstrated knowledge of the different types of abuse that people could be exposed to. However, they had not used this knowledge to safeguard vulnerable people in practice. A team leader had signed each of the daily care records to show these had been checked. Records showed staff had redirected one person when they attempted to discuss the way they were being treated by staff. None of the instances we found had been reported to the registered manager. This meant people were not fully protected from harm or abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Safeguarding people from abuse and improper treatment.

At the time of publication the safeguarding investigation was on-going. We will monitor the situation to make sure any actions following the safeguarding investigation are implemented.

In discussions with the registered manager they displayed a good understanding of their role in protecting people from abuse and improper treatment, where they had been made aware of any concerns of a safeguarding nature prompt referrals had been made to the local authority safeguarding team. All ten support workers we spoke with told us they thought any concerns they raised with the registered manager would be taken seriously and investigated. All of the relatives we spoke with told us they believed Alexandra Park was a safe place for their family member to receive care. One relative said, "It's very safe. I think the whole site is safe." Another commented, "I do feel [My Relative] is very safe." A third relative said, "It's definitely a good place. [My Relative] is safe there."

Medicines were well managed. Since our last inspection the provider had improved procedures to ensure staff had the information they needed to safely administer medicines. Where people were prescribed topical creams, diagrams were in place to indicate the areas the creams should be applied. Where people were prescribed 'as required' medicines, which were given only when needed, such as for pain relief, staff had clear instructions about when they should be administered. Staff had received training in administering medicines and undertook annual competency assessments to ensure their skills and knowledge remained

up to date. Medicines were safely stored. Where people left the home, for example to spend weekends with their family, there was a process to sign out their medicines and records so relatives had all of the information they needed to ensure people received their medicines consistently. One relative said, "I have no issues with medication. They are very good at making sure we have the sheet and everything we need when [My Relative] comes home with us." The registered manager told us they had noted that medicines errors had increased within the service. In response to this the provider had put additional measures in place to ensure medicines were handled safely. At the time of the inspection medicines were only administered by team leaders. Support workers were undertaking additional training and competency tests before they would be able to administer medicines again.

There were enough staff to support people. Each person who used the service received a care package and staff support based on their individual needs. People, staff and relatives we spoke with told us there were always enough staff to meet people's assessed care package. The registered manager told us there had been on-going recruitment since our last inspection, and at that point the service were fully staffed so did not need to rely on staff undertaking overtime in order to meet people's needs. Some people who used the service had fluctuating needs, because of this an additional member of staff was always on duty to work across Alexandra Park to provide additional support if people needed it.

We examined four staff records. We saw recruitment procedures had been followed. Staff files included evidence of staff application forms, interview notes, references from previous employers and Disclosure and Barring Service (DBS) checks had been made. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role.

Risks to people's safety had been considered and information had been provided to staff about the actions they should take to keep people safe. Care records showed a range of risk assessments had been carried out related to various activities and people's specific health conditions, such as falls or epilepsy. The registered manager told us risks were considered in a positive way, and that steps were taken to maintain people's safety without limiting their independence. We saw examples of this within people's care records. For example one person's records detailed that they were able to access the community and use public transport without needing staff support. Their assessment detailed the way risks had been minimised, by checking the person had access to a phone if they needed to call staff and access to enough money for their trip. Wider risk assessments were also in place for the operation of the service, such as fire risks and the Control of Substances Hazardous to Health (COSHH).

Where accidents had occurred these had been reviewed and investigated. Records detailed the nature accidents, what action had been taken, and whether they had resulted in any injuries or other issues. The registered manager showed us the analysis which was carried out to determine if there were any trends in accidents, this analysis was shared with the provider on a monthly basis to provide additional oversight and monitoring of the safety of the service.

We visited six people's bungalows and looked around the communal areas of Alexandra Park. We saw they were clean and well maintained. Records were kept in each person's home to show checks were undertaken of the electrics, boilers and any equipment in use to ensure they were fit for purpose. Where able to, people were encouraged to clean and tidy their own bungalow. Records were in place for staff to follow so that cleaning tasks were carried out on a regular basis.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals.

The provider had not always acted in accordance with the MCA. A number of decisions had been made on people's behalf which the provider could not evidence had been made in line with the principles of the MCA. One person had restrictions imposed on their planned activities if they had displayed behaviour which posed a risk to themselves, staff or property. The provider had not kept paperwork to show how the principles of the MCA had been adhered to, and that the decision was in the person's 'best interests' or was the 'least restrictive' option. This decision was not adequately care planned, so staff did not have information about how carry out restrictions consistently. It was not monitored to ensure it was being imposed appropriately. Whilst the person's care manager and family had been involved in making the decision, the provider had not sought the views of the positive behaviour team or any other clinical input to ensure the decision had been properly considered.

Whilst we found some mental capacity assessments were in place. These were often broad, and were not decision specific. For example we saw a number of records which stated they were assessing 'If [person's name] can understand and sign care plans' as opposed to being in place for significant, specific decisions.

Records showed that the principle of 'presumed capacity' had not always been followed. We saw a number of entries within two people's records which showed staff had not respected people's right to make decisions. Basic decisions such as what people would like to wear, or to eat, or where they would like to spend their time in their home had made for people, and there was no information available as to why it was considered that people did not have the capacity to make these choices.

Care records described people's routines and highlighted the decisions which had been made in people's 'best interests'. Care plans described people 'enjoying' aspects such as helping to clean their home, or receiving personal care but also stated this planned care was in people's 'best interests'. Plans of care did not describe to staff how they should respond if people did not want to follow their routine. Two people's records showed staff were very rigid about the order of routines and had not allowed people to make choices; they described staff withdrawing from these two people if they did not want to follow their routine. Care plans had not included adequate information for staff about how people's right to make their own choices should be balanced against people's planned routines.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Need for Consent.

In discussions with the registered manager and staff, we found they were knowledgeable about the MCA,

and how it was applied on a day to day basis for people who used the service. Staff gave us examples of how they promoted people's right to make choices. Relatives we spoke with told us their family members were provided with choices. One relative said, "They go out of their way to make sure that [Person's Name] gets to make choices." Another relative said, "Whenever I'm there, and whatever I read in records, staff are including [My Relative] in any decisions."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider was acting in accordance with the Deprivation of Liberty Safeguards. Where people were under supervision by staff to keep them safe, applications had been made to the local authority or to the Court of Protection. The Court of Protection is a superior court with jurisdiction over the property, financial affairs and personal welfare of people who do not have mental capacity to make decisions for themselves.

Some of the people who used the service displayed behaviour which may be challenging to staff. Detailed plans were in place which described to staff how they should respond to people when they displayed anxiety or aggression. However these plans were not always followed in practice. Three of the nine people's records we looked at included records of staff responding to people in ways which did not match their behaviour support plans. In discussions with us support managers and staff they told us these responses were beneficial to the person. However they not been added to the support plan or anywhere in the person's planned care records. This meant this care had not been properly assessed, planned or evaluated to ensure the care people received was consistent and met their needs.

Whilst incident records had been completed where people had displayed behaviours which may challenge staff, these had not been monitored to determine if there were any trends. The acting manager and support managers told us they did not monitor trends in people's behaviours ordinarily, as they said some people, as part of their needs, would always display some elements of behaviours which posed a risk to themselves or other people. However both the acting manager and support managers acknowledged that if monitoring was in place, they may have identified the safeguarding incidents which we found during the inspection, as the people involved had started displaying behaviours which challenged staff more frequently.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled person-centred care.

Restraint was practiced where people posed a significant risk to themselves or to other people. Staff had all been trained in restraint techniques and their competency in carrying out restraint was assessed before they were able to work with people. Additional records were kept in relation to restraint, in line with best practice guidance, to reflect on the situation which led to the restraint and the way it had been carried out. This additional monitoring also ensured that the use of restraint could be audited and enabled the provider to monitor that it was being used appropriately. We found details of two incidents of restraint which had not been detailed within restraint records.

All of the relatives we spoke with told us they thought staff had been well trained and could meet the needs of people living at Alexandra Park. One relative said, "I would say the training is very good. Any situation seems to be managed quite well. I've got no issues." The provider had identified a program of training which they considered mandatory for staff to be able to carry out their role. This included training such as health and safety, moving and handling, safeguarding and other modules which were aimed at equipping staff with the skills to meet the complex needs of people who used the service. All staff had undertaken non-abusive psychological and physical intervention training (NAPPI). Some additional training was also delivered to

staff depending on the needs of the person they supported. For example all staff who supported one person had to attend training in epilepsy. We saw from the training matrix that training was in date. Staff were contacted in advance when their training needed to be renewed. Many of the training courses were delivered by the provider's training team.

New staff received all of their mandatory training during a week-long induction, which staff attended before they started working at Alexandra Park. The induction had been designed to incorporate the Care Certificate. The Care Certificate is a set of minimum standards for care workers. The induction included competency assessments to demonstrate staff understanding and to ensure staff had the skills to deliver care safely. This meant processes were in place to provide staff with training to equip them for their roles. We spoke with one member of staff who had recently started working at the service. They described their induction as, "Very comprehensive and relevant to the people's care needs."

Staff we spoke with told us the training they received was suitable to be able to carry out their role. One staff member said, "There is enough training." Another staff member said, "The training is appropriate as a baseline. There will always be some parts of care that you won't learn until you are working with the individual. But there is always someone to go to for advice; the other team leaders are great." A third staff member told us, "I would like to see more PBS (Positive Behaviour Support) training on site, it's a component of NAPPI now so I'm sure it will be coming. PBS flips things around in the way it's described and that would be beneficial for staff."

Staff were given the opportunity to develop their skills, and were encouraged to undertake an NVQ in social care. Staff told us they were supported by their managers and the organisation. They told us they attended one to one meetings with their supervisor every 6 weeks or more often if they felt they needed it. Records confirmed these meetings were held regularly. Supervisions sessions are important so staff can discuss their role and the needs of people who they support with their supervisors. Appraisals, to discuss staff training needs and personal development goals, had been held yearly.

People were supported to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. We saw evidence in people's care records of input from GPs, specialist nurses such as the epilepsy nurse team, dentists, opticians, and occupational therapists. We saw the service had made contact with the positive behaviour support team from the local health trust for some people who used the service, although we noted they had put restrictive practices into place without consulting this team for another person. Staff supported people to attend their appointments in the community, such as hospital appointments with psychology services or attending appointments at their GP practice.

People's food and hydration needs had been assessed. Records included information about people's likes and dislikes. One person's care records described how staff were supporting them to manage their weight and eat a healthy diet. This person had been successful in losing weight and moving towards a healthier BMI. We spoke with their relative who told us, "The service have been brilliant. [Person's name] has so much more confidence now. They'll go out for a walk or swimming now, when they would never want to do that before." All of the relatives we spoke with told us their family member was involved in meal planning and shopping for their groceries. Some also told us their relatives would also take part in food preparation. One of the people we met with told us they enjoyed baking, and a relative described how their family member had helped to cook Christmas dinner for the people who stayed at Alexandra Park on Christmas day.

People lived in individual bungalows. These had been adapted to people's individual needs, for example some had been fitted with showers instead of baths, some people had reinforced walls and floors. People's bungalows were decorating individually. We visited six people's bungalows. We noted most had a homely

feel, but found one was very stark and bare. Staff informed us that was the person's choice, and met their individual needs. They told us they were working with the individual, and sourcing specialist furniture so that they could make the home feel more homely. There was communal space available in the main hub building, and this was used for parties, training sessions and arts and crafts.

Requires Improvement

Is the service caring?

Our findings

Whilst our observations, and feedback from people, relatives, and staff was very positive, we found evidence within people's care records that they were not always treated with dignity and respect.

Two of the nine people's daily records that we looked at, detailed interactions where staff had told people they were 'silly' or 'naughty'. Staff had described restrictions they had imposed as a punitive response to people. We immediately reported our findings to the registered manager, and the staff involved were suspended pending an investigation.

Where restrictions were in place for people's safety, information for staff had not always been provided to ensure that people's independence was promoted. For example some people's access to their kitchen was restricted. We looked at one person's risk assessment and care plan related to their access to their kitchen. It provided staff with lots of details about what they should not do, for example not to allow the person to be in the kitchen during food preparation, but did not set out how staff could encourage the person to be independent despite this restriction. We saw on one occasion the person had become distressed as they had wanted to wash their dishes, but were not allowed access to their kitchen. We could not see if any alternatives had been offered to the person, for example to bring the washing up bowl into the person's lounge so they could carry out this task themselves.

Other examples within two of the nine people's daily records we looked at, detailed that staff had not respected people's choices. On one occasion staff had requested that a person changed their chosen clothes before they would be able to go on their planned visit. On a number of occasions one person had been told they needed to sit at a table rather than on the sofa where they wanted to eat their meals. This meant people's right to autonomy was not always respected.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Dignity and respect.

Whilst we found these concerns, we also saw evidence of good practice and caring interactions between people and staff. People and relatives we spoke with told us they were very happy with the service. One person said, "I like all the staff." A relative said, "The staff are all fantastic."

We met with six people who used the service in their bungalows. They were supported by staff, and we saw people appeared comfortable and relaxed. When people talked with us about their hobbies and the activities they enjoyed doing, they included their care worker in the discussion. One person talked with us about their favourite films, they reminded the staff of when they had watched it together and the bits they had particularly enjoyed. People and staff seemed to know each other very well and appeared to enjoy each other's company.

Relatives told us staff were caring. One relative said, "[My relative] feels stable and secure with the staff. They have trust in them. They all bring something different. We're frightened in case we lose one (if a staff

member was to leave). They have a great understanding of [My relative]. All the staff they have brought in are excellent. It makes us happy. They've told us, 'It's not like coming to work,' they love being with [Person's name] it's not like a job to them."

All of the support workers we spoke with told us they were proud to work for a caring organisation. They told us their whole purpose was in helping people to live full and happy lives. One member of staff said, "I love working with [Person's name], we know what makes him happy so we'll do whatever we can to help him enjoy life. There is such a sense of satisfaction when [Person's name] has had a great day and is pirouetting around their bungalow."

Relatives told us people were involved in planning their care. One relative said, "[My relative] is involved. When I'm there, I witness that. From everything I read in their care records and from what staff say they are completely involved. They do their own activity plan and menu every week. I'm always invited to any reviews (annual reviews of people's care)"

Care records contained information about people's family life, hobbies and needs. They had been written from the person's point of view for example one person's care record stated, "I have great smile and a good sense of humour."

The registered manager told us they referred people to advocacy services if they felt they needed support to make decisions. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. We saw from records one person was using an advocacy service at the time of our inspection.

Staff and the registered manager, gave us examples of where they felt they had gone 'the extra mile' to enrich people's lives. Staff told us one person wanted to get a dog, and they had recently supported them to do so, helping them to register with the vet and to purchase the items they would need to look after the dog.

Information had been provided for people in an 'easy read' format, which included images and the use of language to meet people's needs. Information presented in an 'easy read' format included details about the service, what people should expect from the service and details about what people should do if they had any complaints.

Requires Improvement

Is the service responsive?

Our findings

Care had not always been planned in a way which took into account their mental health and emotional needs. One person's care records described that they did not like talking about their emotions or any previous incidents they had been involved in. However we saw from the person's daily care records that they attempted to discuss their emotions regularly with staff. Staff detailed their response as "prompted not to discuss", or "[Staff member name] said let's not discuss it." Staff had not been provided with sufficient information to ensure they responded to the person's attempts to discuss their feeling in a consistent way, or in a way which would take into account their emotional needs.

Records showed people's plans of care had been evaluated regularly, however it was unclear as to what the evaluation process entailed as no information had been recorded apart from the date.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 entitled person-centred care.

Records were not easy to follow. Information about the care people received was kept within three large files. Information had been duplicated at times, and in other places documents had not been fully completed. Some documents were very brief. We saw one person's life history consisted of three short bullet points. Whilst we were able to build a picture of people and their needs from the records, they were very time consuming to go through, and it was difficult to find out where specific information was kept. For example we saw important information about a device one person had to control their epilepsy was mentioned within a hospital passport, but not within their epilepsy management plan. This was detailed and specific, but stated the person's epilepsy was well managed, whereas other records showed they experienced seizures regularly.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 entitled good governance.

Whilst we found these shortfalls in records, we noted some assessments and plans of care were well completed and gave staff clear instructions about how to meet people's individual needs. Information for staff relating to people's communications needs was in depth. They included records about frequent phrases people may use, details on their body language and how staff should respond. A video was also available for staff to watch, to help them understand one person. This person used hand gestures to communicate, and staff were able to watch a video of another staff member showing them what the gestures meant. Staff told us this was very useful and meant any new staff were able to understand how to support the person and to provide continuity of care.

Since our last inspection the service had introduced core teams of staff to support people. This meant that people should always be supported by staff who they knew, and who knew their needs well. Relatives told us the core teams usually worked well, and that their relatives appeared more comfortable and settled with consistent staff teams. One relative said, "There is more stability now. It's fantastic, they have the best team

supporting [My relative}" Another relative said, "The staffing has been working really well. At one time it felt like [My relative]'s team changed all of the time, but it's got much better."

People were supported to take part in a range of activities in the community and within Alexandra Park. People told us they enjoyed going swimming, to exercise classes, and shopping. We saw from people's daily records that people's activities were determined by their preferences. Whilst at Alexandra Park people took part in crafts at home, or attended the main hub for parties or social events.

Complaints records were well maintained. Complaints and feedback were recorded within complaint records. We saw investigations had been carried out and the person who had made the complaint had been kept up to date with the progress of investigations and the outcome. One of the relatives we spoke with told us they had made a complaint in the past. They told us it had been well managed and quickly responded to. They told us it had been resolved to their satisfaction.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Care Quality Commission since February 2015. The registered manager was present during the first two days of our inspection and assisted us with our enquiries.

The provider had failed to ensure there was adequate governance and oversight to identify and address the issues which we identified at our inspection. Systems and processes were not fully in place or operated effectively, to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The registered manager showed us the quality assurance system which was completed regularly. This included audits on medicines, care records, and premises in addition to monitoring of safeguarding incidents, complaints and accidents and incidents. These records were shared with the provider who monitored that any action plans created in response to the quality checks were fully completed. Despite these being in place the systems had failed to identify and address the shortfalls which we found.

During our inspection we found incidents of a safeguarding nature had been detailed by staff within the daily records. These records had been signed by a team leader to show they had been read, but the incidents had not been identified by any staff within the service and were not picked up during the monthly meeting between team leaders and service managers to discuss the service provided to people.

The principles of the Mental Capacity Act 2005 had not always been followed, and restrictions were imposed without adequate planning and monitoring. The care people received had not always been planned, evaluated and based on assessed needs. Records showed that people were not always treated with dignity and respect. Records were not always fully completed, and important information had not always been included within support plans. Care plan audits had not highlighted the concerns which we found. The provider had an internal team who assessed the quality of the service; however the provider audits had also not identified these shortfalls. This meant auditing systems in place had not been effective or driven improvements.

During the inspection we noted that some parts of the quality assurance system, such as care record audits, were assigned to team leaders, who themselves were involved in delivering care. This meant issues with care planning and mental capacity assessment may not have been picked up on because the staff member auditing the quality of the records had been responsible for writing them. Since our last inspection the registered manager had been given the responsibility of area manager for the provider in addition to their role of registered manager. The registered manager had previously been supported by three support managers, however since our last inspection these had been reduced to two managers. We considered this had a detrimental impact on the oversight of the service.
This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

Feedback from people, relatives, staff and healthcare professionals about the leadership at the service was

positive. Relatives told us the registered manager and the support managers had made improvements to the service. One relative said, "There has been a vast improvement since [Registered Manager] and [Support Manager] took over. Before we had hundreds of hiccups. But they have worked on communication with us. We are now informed of everything. [Support Manager] is fair but will not stand for any skiving. The staff are on their toes and are enthusiastic about their jobs." Another relative said, "I've spoken with [Registered Manager] a few times. I'm confident if I took anything to him he would deal with it.

Staff told us it was a supportive organisation to work for. One staff member said, "They [management] do a really good job, in general. It's a hard site to work on, but it's managed quite well. Everyone who is here likes it here." Another staff member said, "I think it is well managed. There is lots of potential, and lot of good work has already occurred. Change doesn't happen overnight, it can take a while, but it is a work in progress. It's a cracking site."
The provider describes their values on their website, stating, "We are driven by a straightforward belief that everyone deserves a life of happiness, dignity, achievement and inclusion." Staff we spoke with all displayed these values, with many of them telling us the thing they enjoyed most about their job was supporting people to be happy and included in the community.

Feedback had been sought from people who used the service, staff and relatives. Surveys for people who used the service had been created in an easy read format, with pictures to aid people's understanding. The surveys had been sent out in November 2016 and at the time of our inspection the results had been analysed, but an action plan had not yet been created. The results were mainly positive. Questions about staff approach, dignity and respect and manager visibility had been answered with 100% satisfaction. The service had received some feedback on areas for improvement such as staff training and consistency. The registered manager told us an action plan would be created and shared with people and relatives as to the steps which the service would take to make further improvements.

Meetings were held regularly for people who used the service to discuss any upcoming events or trips. Staff meetings were held monthly in core teams, to discuss both the service, the support each individual person received, as well as any other staff communications. Staff we spoke with told us the management team were approachable and they could discuss any queries, or feedback on improving the service at any time.

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 Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate or met their needs. Assessments of the needs and preferences for care and treatment of people were not always up to date. Regulation 9 (1)(a)(b)(3)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with respect and dignity. Their independence was not always promoted. Regulation 10(1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people were unable to consent because they lacked capacity, the provider had not always acted in accordance with the Mental Capacity Act 2005. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service were not safeguarded or protected from the risk of abuse or improper treatment. Regulation 13

(1)(2)(3)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to assess, monitor and improve the quality of the service provided, were not robust enough to identify and address shortfalls. Records were not always an accurate account of the care people received. Regulation 17(1)(2)(a)(c)(f)