Pendle Residential Care Limited

Calder View

Inspection report

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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

This inspection was carried out on 29 and 30 March 2017. The first day of the inspection was unannounced.

Calder View is a mid-terraced, garden fronted house located near the centre of Colne. Shops and services are a short distance away and transport links are nearby. There are six single bedrooms and two communal lounges. There is an enclosed garden area to the rear of the home and roadside parking to the front of the home. The service provides accommodation and personal care for up to 6 people with mental ill health. At the time of the inspection there were 6 people accommodated at the service.

The service was managed by a registered manager. However the registered manager was not on duty at the time of the inspection. 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.

At the previous inspection we asked the provider to make improvements in relation to a lack of robust recruitment procedures prior to staff working at the service. We received an action plan from the provider indicating how and when they would meet the relevant legal requirements. At this inspection we found the required improvements had been made. However we identified further shortfalls in recruitment practices which meant there was a continued breach of one regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We have also made recommendations on improving medicine management processes and promoting healthy eating.

The people we spoke with indicated satisfaction with the care and support they experienced at Calder View. Although people had some concerns about the behaviour of others, they did not express any concerns about the way they were treated or supported. They had access to information on abuse, protection and safeguarding. Individual risk assessments had been carried out and staff were given instructions about how to manage any risks to help keep people safe.

Staff expressed a good understanding of safeguarding and protection matters; they knew what to do if they had any concerns. There were enough staff available to provide care and support and we were told staffing arrangements were kept under review.

Systems were in place to maintain a safe environment for people who used the service and others. We found there was a safety matter needing attention; action was taken to put this right during the inspection.

The service was working within the principles of the MCA (Mental Capacity Act 2005). We found people were

supported to make their own decisions and choices. They were effectively supported with their healthcare needs and medical appointments. Changes in people's health and well-being were monitored and responded to.

People were satisfied with the meals provided at Calder View. People were actively involved with devising menus, which meant they could make choices on the meals provided. Some people were supported to cook their own meals as part of their skill development.

People made positive comments about the care and support they received from staff. We observed positive, sensitive and respectful interactions between people using the service and staff.

There was a focus upon promoting and maintaining independence skills. Each person had a care plan, describing their individual needs and choices. This provided clear guidance for staff on how to provide support. People's privacy, individuality and dignity was respected.

People were supported to pursue their interests and lifestyle choices, including activities in the local community. They were supported to keep in touch with their relatives and friends. People's well-being was monitored and reviews of their needs were regularly held.

There were processes in place for dealing with complaints. There was a formal procedure to manage, investigate and respond to people's complaints and concerns. People could also express concerns or dissatisfaction during their care reviews and in residents meetings.

There were systems in place to ensure staff received regular training, development and supervision. The service had a management and leadership team to direct and support the day to day running of the service. There were systems in place to consult with people who used the service and staff, to assess and monitor the quality of their experiences.

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.

Staff recruitment did not include all the required character checks for the protection of people who used the service. There were enough staff available to provide safe care and support. Staff knew how to report any concerns regarding possible abuse and were aware of the safeguarding procedures.

We found there were some safe processes in place to support people with their medicines. However, medicine management practices needed some improvement for people's well-being and safety.

Processes were in place to maintain a safe environment for people who used the service. However we found there was a safety matter requiring further attention.

Is the service effective?

Good

The service was effective.

People were encouraged and supported to make their own decisions. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA).

People told us they enjoyed the food at the service. However we made a recommendation about healthy eating and nutrition. People's health and wellbeing was monitored and they were supported to access healthcare services when necessary.

Processes were in place to train and support staff in carrying out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

People made positive comments about the friendly and caring attitude of staff. We observed friendly, sensitive and respectful interactions between people using the service and staff.

Staff were aware of people's individual needs, backgrounds and personalities, which helped them provide personalised care.

People's dignity and personal privacy was respected. People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Processes were in place to find out about people's individual needs, abilities and preferences. People had opportunity to be involved with planning and reviewing their support. Processes were in place to monitor, review and respond to people's changing needs and preferences.

There were opportunities for people to improve and develop their skills and abilities. People were supported to take part in a range of individual and group activities, further options were being considered.

There were satisfactory processes in place to manage and respond to complaints, concerns and any general dissatisfaction with the service.

Is the service well-led?

Requires Improvement

The service was not consistently well–led.

People made positive some comments about the management and leadership arrangements at the service. The leadership arrangements aimed to promote a consistent management of the service.

There were processes in place to regularly monitor the quality of people's experience at the service. However we found the some of the checking systems needed improvement.

Calder View

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 checked 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 29 and 30 March 2017. The inspection was carried out by one adult social care inspector. Prior to the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted various professionals including: the local authority contract monitoring and safeguarding teams and care coordinators. We reviewed information we had and used it to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection we spoke with four people who used the service. We talked with five members of staff, the team leader and area manager. We also spoke with the registered manager following our visit.

We spent time with people, observing the care and support being delivered. We looked round the premises and grounds. We looked at a sample of records, including two care plans and other related documentation, two staff recruitment records, complaints records, meeting record's, policies and procedures, quality assurance records and audits.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with indicated they felt safe at the service. Their comments included, "Yes I feel safe here, it's okay" and "Most of the time I feel safe." We did receive some comments about how the behaviours and actions of others, which had impacted upon people's experiences at the service. People said, "I just go to my room" and "They know it's upsetting for people and the staff support us." We observed examples where staff positively and sensitively responded to specific behaviours and used tact and diplomacy to defuse matters. We asked people how they were treated by staff they told us, "The staff are all alright, there's no shouting" and "No concerns with staff."

There was information available to people on the service's notice board around protection matters, including leaflets on keeping safe and details of the local authorities safeguarding strategies and 'house rules', which highlighted the expectations around mutual respect and behaviours.

At our last inspection we found there was a lack of robust recruitment procedures for the well-being and protection of people who used the service. This was due to a lack of satisfactory documentary evidence of relevant qualifications and the applicants' integrity. We received an action plan from the provider which told us they would ensure the required recruitment processes were in place by 5 March 2015.

At this inspection we checked if the staff recruitment procedures protected people who used the service and ensured staff had the necessary skills and experience. We looked at the recruitment records of two members of staff. We noted improvements had been made in obtaining copies of certificates to verify applicants had attained the declared qualifications. Some of the required checks had been completed before staff worked at the services and these were recorded. The checks included an identification check and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Information was made available to demonstrate the DBS certificates contained no issues of concern.

However we found there was a lack of information to show all the required checks had been completed. Gaps in employment had not always been recorded, checked and verified. There was a lack of information to show the reasons for leaving previous employment in a care setting had been appropriately pursued. Two written references had been obtained for each applicant. But we found a reference from a previous employer had not been chased up, which meant evidence of the staff members conduct in a previous care setting had not been obtained. Records had not been kept to show any resulting risks to people who used the service had been identified, explored and managed.

Therefore this was a continuing breach. The provider had not ensured robust recruitment procedures were carried prior to staff working at the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way the service supported people with their medicines. All the people spoken with said they received their medicines on time. They said, "I'm aware of all my medicines they went through them

with me" and "My medicines are given to me by staff, but I'm hoping to self-medicate." Each person had a medicine profile record which made reference to the prescribed items, the dosage, amount and any side effects. People had been assessed to check their preferences and ability to manage their own medicines. Records showed people had consented to their medicines being managed by the service.

We checked the procedures and records for the storage, receipt, administration and disposal of medicines. The processes included staff having sight of repeat prescriptions prior to them being sent to the pharmacists.

There was a monitored dosage system (MDS) for medicines. This is a storage device designed to simplify the administration of medicines by placing them in separate compartments according to the time of day. All the records seen of medicines administered were complete and up to date. People were identified by a photograph on their Medicine Administration Record (MAR) which helped to reduce the risk of error. We noted any hand written entities on MAR charts had been checked and signed by two people to verify them as correct.

We found there were specific protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. The protocols are important to ensure staff are aware of the individual circumstances this type of medicine needed to be administered or offered.

We looked at the arrangements for the safe storage of medicines. We found some people's medicines were stored in a 'locker' style cabinet and not appropriately safely and securely stored in accordance with recognised guidance. Although there were no controlled drugs, which are medicines which may be at risk of misuse, we noted there were no suitable storage facilities for such medicines. This meant should controlled drugs be prescribed storage facilities would not meet the requirements of the Misuse of Drugs Act 1971. The shortfalls in appropriate medicines storage were not in line with the provider's medicines policy which stated such facilities were to be provided. During the inspection the area manager took action to rectify this matter and we saw evidence to confirm a suitable medicines cabinet had been ordered. Storage temperatures for some items were not being monitored and adjusted in order to maintain the appropriate conditions. This meant there was a possibility that the integrity of the medicines could be compromised. The team leader took steps to ensure appropriate checks would be carried out.

We noted medication audits had been completed weekly and monthly which showed shortfalls had been identified, learned from and the necessary improvements made. Staff had access to a range of medicines management policies, procedures and nationally recognised guidance which were available for reference. Staff responsible for medicines management had received appropriate training and we noted their competencies had been assessed. There had been six monthly medicine management theory updates; however this had not included a practical assessment of their competence.

We recommend processes for auditing medicine management practices are further developed to identify and rectify shortfalls in a timely way.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. During the inspection we observed an occurrence where a person who used the service accessed the cellar. We were told access to this area was usually kept restricted due to health and safety risks. However it was apparent the locking arrangements were not effective in ensuring the security of the door. The team leader agreed to take action to rectify this matter during the inspection.Following our visit, the registered manager confirmed a new lock had been fitted.

We found health and safety checks were carried out on a regular basis. Hot water temperatures to sinks, baths and showers were being checked. Records showed arrangements were in place to check, maintain and service fittings and equipment, including gas and electrical safety, fire alarms and extinguishers. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out on a regular basis. Kitchen hygiene checks were carried out. There were accident and fire safety procedures available at the service. We noted people who used the service were involved with the fire safety procedures and evacuation drills.

Prior to the inspection we reviewed the information we held about the service relating to safeguarding incidents, allegations of abuse and incidents involving the police. There had been three matters of concern over the last 12 months and which had impacted upon people's well-being and safety. We discussed and reviewed some of the previous safeguarding concerns and ongoing circumstances with the team leader. Records seen showed how safeguarding and protection matters were reported, managed and analysed to reduce the risks of re-occurrence.

We discussed the safeguarding procedures with staff and the managers. Staff spoken with expressed a good understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received training and guidance on safeguarding and protecting adults and children. They had also received training on positively responding to people's behaviours. Staff described how they responded and sensitively supported specific behaviours. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people.

We looked at how risks to people's individual safety and well-being were assessed and managed. Individual risks had been identified in people's care records and were kept under review. There were specific risk assessments in response to people's individual needs and behaviours which included: risk of suicide, self-harm, physical violence, absconding, vulnerability, domestic tasks and independence in the community. There were risk management plans which included actions for staff to follow on minimising the risks to the individual. We noted the risk assessments were kept under review and all relevant staff had signed to confirm their awareness of the risk assessments. One support worker told us, "I am aware of all the risk assessments and risk plans, they are reviewed monthly and we are made aware of any changes." Records were kept of any accidents and incidents that had taken place at the service. Processes were in place to monitor any accidents and incidents so the information could be analysed for any patterns or trends. Referrals were made to relevant health and social care agencies as appropriate.

We reviewed how the service managed staffing levels and the deployment of staff. People spoken with did not express any concerns about the availability of staff at the service. One person commented, "I think there are enough staff. " During the inspection we found there were sufficient staff on duty to meet people's needs. We observed support being provided in a timely and consistent way. Staff spoken with considered there were mostly enough staff on duty at the service. They confirmed action was taken to cover unforeseen and planned staff absences. We looked at the staff rotas, which showed arrangements were in place to maintain consistent staffing levels. We were told staffing levels were kept under review and were flexible in response to people's needs. The team leader said staffing arrangements would always be reviewed during the planned admission of a new person moving into the service. We noted staffing arrangements had been amended and increased in response to people's needs. Arrangements were in place to provide ongoing management support, including on call systems for evenings and weekends.

Good

Is the service effective?

Our findings

The people we spoke with indicated satisfaction with the care and support they experienced at Calder View. They said, "I do like it here," "Things are okay" and "I am fairly happy here."

People spoken with indicated they were involved in matters affecting them. During the inspection, we observed examples where staff consulted with people on their individual needs and preferences and involved them in routine decisions. Staff spoken told us the always consulted with people about their support and lifestyle choices. One support worker commented, "We always ask people and explain things in the least patronising way as possible." The care records we reviewed included signed and dated agreements on consent to care and other matters. We noted people had also signed in agreement with their care plans records. Some people had chosen not to sign their records and their wishes had been respected.

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 the 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. The care planning process included an assessment of people's capacity to make their own choices and decisions.
There was information to demonstrate appropriate action had been taken as necessary, to apply for DoLS authorisation by local authorities in accordance with the MCA code of practice. We noted clear information for the reasons for the applications were included in people's care records and support workers spoken with were aware of the restrictions and legal status of the interventions and agreements in place.

Staff spoken with indicated an awareness of the MCA and DoLS, including their role to uphold people's rights and monitor their capacity to make their own decisions. Records and discussion showed that staff had received training on this topic. The service had policies and procedures which aimed to underpin an appropriate response to the MCA 2005 and DoLS.

We looked at how people were supported with their healthcare needs. People's medical background, mental health diagnosis and healthcare needs were included in their care records. Their physical, psychological and emotional wellbeing was monitored daily and considered as part of ongoing reviews. This meant staff could identify any areas of concern and respond accordingly. The people we spoke with told us they had received attention from healthcare professionals as and when needed. They told us, "They help me with my appointments," another said, "I have regular health checks, including with the GP, opticians and

chiropodist." Records were kept of healthcare checks appointments consultations and outcomes. There were 'healthcare passports' to help share information appropriately with health care service. A mental health 'recovery star' programme was in place, to support people in actively sharing responsibility for managing their mental health care needs. Staff spoken with confirmed health care needs were monitored and they supported people as appropriate with appointments.

We looked at how the service supported people with their nutritional needs. People made positive comments about the meals provided at the service. They told us, "The food is home-made and cooked from scratch" and "I do food shopping and cook for myself and the others." People also said they enjoyed take-aways and trips out to local cafes. Care records included information about people's individual dietary requirements and any risks associated with their nutritional needs. People's weight was checked at regular intervals and records were kept of the food people had eaten. This helped staff to monitor risks of malnutrition and support people with their diet and food intake. Specific diets could be catered for in response to cultural and religious needs.

The four-week menu was seen to be readily available. This had been discussed with people to include their preferences and suggestions. One person told us, "We can influence the menus at the residents meetings." The main meal was served in the evening and alternatives were routinely offered. Various recipes had been obtained, printed out and filed together for reference, there were also photographs of meals to show and promote the choices offered. Staff indicated healthy eating was encouraged and people were supported to choose healthy options. We noted fresh fruit and vegetables were available. The menus we looked at showed variety of meals were offered. We did note there appeared to a repetition of 'chips' on the menu, we discussed this with the team leader who agreed review this recurrence. Mealtimes were flexible and people could eat at different times if they preferred. People were involved in preparing and cooking their own breakfast and lunch. They made drinks for themselves whenever they wished.

We recommend that the provider seeks advice and guidance from reputable sources, about supporting people with their nutritional needs and healthy eating.

People were satisfied with the accommodation and facilities available at Calder View. One person commented, "I'm okay with my room." We noted some improvements had been made to home, including new furnishings and decoration. Outside areas had also been developed, including the provision of a new smoking shelter and some structural repairs to the building. We noted some areas of the environment were in need of attention, such as general décor inside and window frames outside needed painting. There was also a lack of suitable office space which meant the registered manager had a desk in the lounge. We discussed these matters with the area manager who told us plans were underway to continue with the programme refurbishment following specific structural developments at the service.

We looked at how the service trained and supported their staff. Arrangements were in place for new staff to complete an initial three week 'in-house' induction training programme. Staff we spoke with confirmed they had received the training. The induction training incorporated as appropriate, the Care Certificate training modules. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. Staff spoken with told us about the training they had received. They confirmed that there was a rolling programme of learning and development at the service. This included: food safety, health and safety, substance misuse, mental health awareness, fire safety awareness and emergency first aid.

The service supported staff as appropriate, to attain recognised qualifications in health and social care. The majority of staff had attained a Level 3 National Vocational Qualification (NVQ) in health and social care, or

were working towards a Quality and Credit Framework (QCF) diploma in health and social care. The team leader had signed up to complete the QCF diploma level 5 in leadership, for health and social care.

Staff spoken with indicated they had received one to one supervisions with a member of the management team. This provided the opportunity to discuss their role and responsibilities in providing support for people who used the service. We saw records of supervisions held and noted plans were in place to schedule supervision meetings. Processes were in place for staff to receive an annual 'competency framework' review of their work performance; this included a self-evaluation of their skills, abilities and development needs.

Good

Is the service caring?

Our findings

The people we spoke with made positive comments about the staff team and the care and support they received at the service. Their comments included, "The staff are friendly and chatty" and "The staff are all good." We found Calder View had a friendly and welcoming atmosphere. We observed positive and respectful interactions between people using the service and staff. Staff showed kindness, compassion when they were supporting and encouraging people with their daily living skills and activities.

We found positive relationships were encouraged. There was a 'keyworker' system in place. This linked people using the service to a named staff member, who had responsibilities for overseeing aspects of their care and support. The system aimed to provide a more personalised service and develop beneficial and trusting relationships. People's care records included their background history, cultural needs and religious beliefs. Their individual skills and abilities, matters of importance to the person and how they could best be supported were highlighted. There was a 'one page profile' which was written in a person centre way and included 'what makes me happy,' and 'what's important to me.' Important relationships were highlighted and people told us they were supported to keep in touch with family and friends. Staff spoken with were knowledgeable about people's individual needs, personalities and backgrounds. They told us they were familiar with the content of people's care records. One support worker said, "We get to know people as individuals, we go through their care records and read up on their backgrounds."

People were supported to do things for themselves. For some people this could include motivating people to develop practical life skills and make their own decisions. One person told us, "I am hoping to be more independent and staff are supporting me with this." Staff spoken with understood their role in providing people with person centred care and told us how they supported people and promoted their independence and choices. During the inspection, we observed people doing things for themselves and others. People explained they went out shopping, cooked some of their own meals, tidied their rooms and did their own laundry. We discussed with the team leader and staff, further ways of constructively motivating and empowering people with day to day matters as part of their ongoing development.

We spoke with people about their privacy. People had free movement within the service and the rear garden area they could choose where to spend their time; however there were some expectations around respecting other people's privacy of personal space. All the bedrooms were single occupancy and people could spend time in their rooms whenever they chose. Bedroom doors were fitted with suitable locks and people had keys to their rooms. We observed the manager and staff respecting people's private space by knocking on doors and waiting for a reply before entering. One person commented, "I can go to my room when I want. I have a key to my room; staff always knock before coming in." Staff described practical examples of how they upheld people's privacy and promoted confidentiality of information.

Staff described specific instances of how they supported people discreetly when accompanying people in the community. They explained how they would respond should a person's manner or behaviour attract the attention of members of the public. They described the methods they would use to positively diffuse the situation and offer reassurance in the person's best interest. Staff did not wear uniforms which meant

people were provided with support in a discreet and dignified way.

We observed that people expressed their views and opinions during daily conversations. They were routinely offered choices and encouraged to make decisions. Residents meetings had been held. This provided the opportunity for people to make suggestions, be consulted and make shared decisions. We noted from the records of meetings that various matters had been raised and discussed. The team leader said plans were in place to hold meetings on a four weekly basis.
Some people told us they were not interested in attending the meetings. We therefore discussed with ways of encouraging people's participation and involvement with consultation meetings. This could further empower people and hopefully help to raise their self-esteem.

There was a range information for people to access and be kept aware of their rights and choices. Including the guide to the service, leaflets and proposed activities, complaints procedures and the details of local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. The names of the staff on duty for the day, was displayed, this was to keep people informed of the members of staff due to be available to provide their support. We noted the service's CQC rating and a copy of the previous inspection report was on display at the service. This was to inform people of the outcome of the last inspection. The provider had an internet website which provided further information about the service.

The service had policies and procedures to underpin a caring ethos, including around the promotion of dignity, privacy and equality and diversity.

Good

Is the service responsive?

Our findings

We looked at the way the service managed and responded to concerns and complaints. The people we spoke with had an understanding of the service's complaints procedure and processes. One person commented, "I have not had any complaints, but I am aware of the complaints procedure." People indicted they could also raise concerns in residents meetings and there was a suggestion box in the hallway, where they could leave anonymous comments if they preferred. Staff spoken with expressed an understanding of their role in supporting people to make complaints and described how they would respond should anyone raise concerns.

There was a copy of the service's 'user friendly' complaints procedure displayed on the notice board. The procedure was also summarised in the guide to the service. This information provided guidance on how to make a complaint along with an indication of how the concerns would be investigated. Information within the PIR indicated that updating complaints forms for people to use was a matter for future development at the service. The service had policies and procedures for dealing with any complaints or concerns. The area manager explained that complaints were kept under review to monitor trends and proactively make improvements.

The PIR indicated there had been one complaint at the service in the last year. We reviewed the records of the complaint and found the process included informing the complainant of the outcome of the investigation. This provided an indication that all matters raised were being taken seriously and responded to. However some of the complaints records, including the actions taken to investigate matters were not readily available for us to review. The area manager took action to address this matter during the inspection.

We looked at the way the service assessed and planned for people's needs, choices and abilities. We found assessment process was comprehensive and covered a wide range of needs and abilities, including: personal history, mobility, personal care, education and employment history, psychiatric history, behaviours that challenge and psychological well-being. The team leader explained that the admission process was tailored to the needs of the individual. This was to ensure their needs and choices could be appropriately and effectively met. People were encouraged to visit Calder View and could stay for lunch or an evening meal. This helped with the ongoing assessment process and gave people the opportunity to meet with others, see the accommodation available and experience the service. We were told that compatibility with others using the service was a focus for consideration during the admission process. We also discussed the processes for emergency admissions and noted the services' policy had recently been updated to ensure appropriate assessments were carried out in a timely way.

Each person had an individual care plan. All of the people we spoke with indicated an awareness of the content of their care and support plans. There was an electronic care planning system in place. Staff had the use of computers and used their own personal login details to access the information. The system was designed to enable the assessment and recording people's identified needs and preferences, which were then linked with action plans providing direction in response to the areas of need. We reviewed two care plans and found they included details of people's routines, behaviours, likes and dislikes and how best to

provide their support. The care plans were comprised of separate sections. Each section identified a specific area of need such as; medication, mental health diagnosis, behaviours, personal care, activities, finances, relationships and shopping. Included were the expected outcomes and details of the action to be taken in response to meeting needs and preferences.

The care plans were written in a person centred way and were reflective of people's needs and choices. Records were kept of people's daily living activities, their general well-being and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours, accidents and incidents. We observed 'hand over' meetings between staff to communicate and share relevant information. These processes enabled staff to monitor and respond to any changes in a person's needs and well-being.

The care planning system generated reminder's for reviews and indicated when care plans had been updated. There was evidence that the care plans were reviewed and updated regularly with the involvement of people who used the service. One person told us, "They review my care plan with me." There were also records of reviews with the involvement of others, including care coordinators, psychiatrists and social workers. There were also some paper care plan records which had been made accessible to people who used the service. Some included illustrations to help make the wording more understandable to people.

Goal planning and skill development was included within the care planning process. One person explained, "I'm doing stuff all the time. I go twice a week to college, for maths, English and health and safety and I do some voluntary work." People told us how they were supported to engage in activities within the local community and pursue their hobbies and interests. They indicated they were mostly satisfied with the range of activities offered at Calder View. The notice board displayed information about proposed daily activities, also details of the various resources available in the local community. People had been supported on a one to one basis and in groups to attend community events and chosen leisure activities. These included, visiting relatives, shopping, local walks, cafes and attending social centres. "I go out walking each day" said one person. People also told us they had enjoyed baking sessions and gardening at the service. We were also made aware of future plans to go swimming, attend concerts and the introduction of chickens and a chicken coup. We looked at records of people's participation in activities which provided an indication of the value of their experiences and their progress. Information within the Provider Information Return (PIR) told us there were planned improvements for identifying and researching more suitable external activities, this was to offer people further opportunities for friendships, skill development and confidence building.

Staff spoken with expressed a practical awareness of responding to people as individuals. They told us the care plans were useful and informative, they said they had ongoing access to them during the course of their work. We observed people being supported and responded to in various ways, in accordance with their care plans, risk assessments, decisions and choices.

Requires Improvement

Is the service well-led?

Our findings

People spoken with had an awareness of the overall management arrangements at the service. They did not express any concerns about how the service was run. One person told us, "I think it's well run, the management is okay."

There were systems in place to monitor the quality of the service. This included a system of daily, weekly and monthly checks. The area manager carried out monthly compliance visits and the findings were shared with the registered manager for action. Audits were in place to monitor areas such as, medicine management processes, care plans, staff training, health and safety and the control and prevention of infection. We noted there were examples where shortfalls had been identified, addressed and kept under review as part of an action plan. However, at our last inspection we found shortfalls in recruitment procedures relating specially to verifying applicants qualifications and integrity. At this inspection we found progress had been made with this aspect of the recruitment process. Yet we noted there were shortfalls ensuring all the other required checks were carried out and recorded. This showed there was a lack of effective auditing processes to identify and achieve improvements relating to safe staff recruitment procedures which had resulted in a continuing breach of the regulations. We also found some improvements were needed with medicine management and a health and safety matter which was progressed during the inspection.

There was a manager in post who had been registered with the Care Quality Commission since 2011. The registered manager had attained the Quality and Credit Framework (QCF) diploma level 5 in health and social care leadership. The registered manager had developed links with the local provider network and with local commissioners. This helped to develop up to date and good practice across the service. There was also a team leader with designated responsibilities for the day to day running of the service.

The registered manager and team leader had responsibilities for other services in the organisation, but spent regular time at Calder View. If the registered manager or team leader was not present, a member of staff with designated responsibilities was identified as a shift leader. There were daily 'shift planners' which were completed to highlight specific roles, duties and responsibilities of the team members on duty. Additionally, there were on-call management arrangements. This meant a member of management was always available for support, direction and advice. The management team was supported and monitored by an area manager and there were regular meetings with managers from other services in the organisation.

Information within the PIR told us that the registered manager had previously attained 'manager of the month award' within the organisation. Staff had signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. We were also told of the provider's staff recognition scheme and that a support worker had achieved an award for a gardening project at the service. The service had achieved the Investors In People (IIP) award in July 2016. IIP is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in employee support and development.

Staff were well informed and expressed a good working knowledge of their role and responsibilities. The

service's vision and philosophy of care was reflected within the services written material including, a vision statement, the statement of purpose and policies and procedures. Staff had been provided with job descriptions, a staff handbook and contracts of employment which outlined their roles, responsibilities and duty of care. They had access to the services policies and procedures and processes were in place to ensure they were aware of changes and updates. Staff meetings had been held. We looked at the records of the most recent staff meetings and noted various work practice topics had been raised and discussed. One staff member commented, "We have staff meetings we can contribute to the agenda and make suggestions we are asked individually for ideas."

Staff spoken with indicated the service was well organised and managed. They described the managers as supportive and approachable. Their comments included, "I think the management is okay," "The management is good," "I think we have a good team" and "At the last team meeting we were thanked for all we had done." Staff spoken with were aware of the service's 'whistle blowing' (reporting poor practice) policy and expressed confidence in reporting any concerns.

Processes were in place to seek people's views on their experience of the care and support they received. For example, they had the opportunity to express their views and opinions during residents meetings. There was a suggestion box for people to put forward their ideas for improvements and changes. People were also asked to complete customer satisfaction surveys to help monitor their satisfaction with the service provided. One person told us, "We have had questionnaires to fill in." Staff were also invited to participate in an annual staff satisfaction survey on their views and experience of the service. Results of surveys reviewed and collated with action taken to help improve practice. There were strategic development plans available from the provider, to demonstrate there had been a corporate analysis and evaluation of the service in response to the findings of audit systems and consultation surveys.

There were procedures in place for reporting any adverse events to the CQC and other organisations such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had appropriately submitted notifications to CQC.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate robust recruitment procedures to ensure applicants were of good character and had the necessary skills and qualifications. (Regulation 19 (1)(2)(3))

The enforcement action we took:

Provider issued with a Warning Notice.