Turning Point

Rix House

Inspection report

24 Arncliffe Road
Keighley
West Yorkshire
BD22 6AR

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10 April 2018

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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

We inspected this service on 10 April 2018. The inspection was unannounced.

Rix House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rix House provides accommodation and personal care; it does not provide nursing care.

At our last comprehensive inspection in January 2016 Rix House was rated 'good' overall. However, due to concerns with the way medicines were managed the safe domain was rated 'requires improvement'. We completed a focused inspection in June 2016 to check the issues with medicines had been addressed. We saw some improvements had been made to the medicines management system. However, we could not improve the rating for safe from 'requires improvement' because we did not see evidence of consistent and sustained good practice. At this comprehensive inspection we found some of the persistent issues around medicines management had still not been addressed. Therefore we have rated the service 'requires improvement' in the safe and well led domains. This means the service is now rated 'requires improvement' overall.

Rix House accommodates up to 20 people in one adapted building. The service specialises in caring for adults with learning disabilities. At the time of our inspection there were 14 people living at the home and two people who were staying for a short period of respite care.

The service was working in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was in place. 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.

People received personalised care from staff who were kind, caring and friendly. Staff knew people well and adapted their approach to meet people's individual needs.

Medicines were not always managed in a safe and consistent way; improvements were still needed to ensure people consistently received the right support with prescribed creams, lotions and drops. This issue has been repeatedly highlighted as requiring improvement by the Commission.

Staff knew how to recognise and report concerns about people's safety and welfare. Systems were in place to ensure risks were appropriately managed.

Staff received appropriate training to ensure they had the skills to deliver effective care. Before staff could start work appropriate checks were made to ensure they could safely care for vulnerable people.

The home was clean and tidy and the provider ensured the environment was safe and suitable for vulnerable people to live in.

Staff supported people to engage in interests and activities both within the home and in the local community. Staff respected people's interests and personal pursuits.

People were involved in developing menus which meant they received food and drink which they enjoyed. Nutritional risk was effectively managed.

Staff worked in partnership with other agencies and healthcare professionals to ensure people maintained good health. The registered manager sought local and national initiatives which they could participate in to help improve the quality of care people received.

Staff treated people with compassion, dignity and respect. There was a positive focus on empowering people to be as independent as possible.

There was an open and inclusive culture. People and their relatives were involved in making decisions about their care and how the service operated. Staff respected people's views and responded to their concerns.

Staff continuously sought new ways to communicate with people and ensure everyone had the opportunity to consent to the care they received and express their views. Staff worked in line with the requirements of relevant legislation such as the Deprivation of Liberty Safeguards (DoLS).

Staff told us they would recommend the service as a place to receive care and as a place to work. Feedback about the registered manager was very positive; people told us they were hands on and led by example.

Systems and checks for monitoring the quality of care were in place however they did not always identify and address areas for improvement. Shortfalls in service delivery were not always promptly addressed and sustained.

We identified one breach of legal requirements. 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.

Medicines were not always managed in a safe and consistent way.

Risks to people's health, safety and welfare were identified and managed.

People told us they felt safe. Staff understood safeguarding procedures and how they should report any suspicions of abuse.

Staff were recruited safely and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People's healthcare and nutritional needs were met.

Staff worked in line with the requirements of relevant legislation such as the Deprivation of Liberty Safeguards (DoLS).

Staff received effective training and development.

The premises was designed and decorated to meet the individual needs of people living at the home.

Is the service caring?

Good

The service was caring.

People told us they were treated with compassion, dignity and respect.

Staff involved people in making decisions and used individualised communication techniques to ensure everyone could express their views.

Staff had developed positive relationships with people and knew

how to meet their needs.

People's relationships with family and friends were respected and encouraged.

Is the service responsive?

Good

The service was responsive.

People received care which was personalised and adapted to meet their changing needs.

People were listened to and involved in making decisions about the care they received.

People's preferences regarding their end of life were captured and implemented.

Is the service well-led?

Requires Improvement

The service was not always well led.

Issues with the medicines management system had not been fully addressed despite being repeatedly raised with the provider by the Commission.

Checks of the quality of care provided did not always identify and address areas for improvement.

The provider had an open and inclusive culture and involved people in how the service operated.

Feedback about the registered manager was very positive.

Staff worked in partnership with other agencies.

Rix House

Detailed findings

Background to this inspection

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

This inspection took place on 10 April 2018 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert had experience of care services for adults with learning disabilities. They completed phone calls to speak with the relatives of people who used the service.

Before our inspection we reviewed the information we held about the service which included notifications sent to us by the provider. We contacted the local authority commissioning and safeguarding teams to ask for their views of the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with four people who used the service and six relatives of people using the service.

We spoke with the deputy manager, two team leaders, two care workers and the cook. We observed care and support and looked around the home. We looked at three people's care records, four staff files and other records such as medication records, meeting notes, accident and incident reports, training records and maintenance records. Following the inspection we spoke with the Registered Manager and two health professionals who visited the service.

Requires Improvement

Is the service safe?

Our findings

At our last two inspections we identified medicines were not always managed in a safe way. During this inspection we identified there continued to be areas where improvements were still required. Our main concern was around the management of topical medicines such as creams, lotions and drops. From our review of records, stock checks and discussions with staff we were not able to confirm that people had received their topical medicines as prescribed.

Topical Medication Administration Records (TMAR's) were in place to record when these medicines were given. We found inconsistencies in the completion of these charts. For example, one person was prescribed a skin cleanser and skin protector to be used as directed. Staff told us these medicines should be used whenever the person was supported with personal care. However the TMARs showed inconsistencies in how often these medicines were applied; some days they were applied three times a day, other days they were applied once a day, whereas other days they were not applied at all.

We found a cream in this person's bedroom which was not listed on their TMAR. The cream had no opening date recorded. The label showed it had been prescribed in March 2017. Staff told us the cream should have been disposed of as it was no longer needed. By still being kept in their topical medicines box there was a risk it could have been unnecessarily given. The deputy manager checked the archived TMARs and found the cream was last administered on 16 February 2018. The TMARs showed this cream had not been consistently given as prescribed.

This person was also prescribed a cream to relieve shoulder pain. The TMAR indicated the cream should be applied three times a day when required. Staff told us they could tell when the person needed this cream because they would be more vocal and resistant to staff touching their shoulder. However there was no protocol in place to provide clear instruction to staff on when to apply, no body map to indicate where to apply the cream and no records to monitor why the cream had been applied when it was used. The TMARs showed it had not been consistently given as prescribed.

Another person was prescribed pain relief cream to be applied three times daily. Their TMARs showed it had not been consistently given as prescribed. They were prescribed several different creams. There were not body maps in place to show where all of these creams should be applied.

We found staff had not always completed TMARs correctly. We saw gaps in recording and for one person staff had repeatedly recorded either an 'S' or a '5'. Staff were not able to tell us what this code meant. We also saw staff had used the code 'F' which was for when a medicine was 'not required.' However staff had not always recorded the reasons why medicines were not required.

Monthly medicines checks were completed which identified areas for improvement. However appropriate and timely action was not always taken to address issues. For example, on 15 March 2018 a medication audit identified staff were not always recording the date topical medicines were opened. During our inspection we saw several topical medicines where staff had not recorded the date of opening. Once topical

medicines are opened they should be discarded after specific periods of time because they become less effective and are at risk of contamination. Without recording the opening date staff were not able to judge when to discard these medicines.

Topical medicines were not checked as part of the monthly audit but were included in the daily health and safety checks. However, not all people prescribed topical medicines were included in the health and safety checks. We also found inconsistencies and errors for some people who were included in these checks. This showed us they were not effective.

The service had recently changed the pharmacist they used. We identified an error in the tablet's the pharmacist had supplied for one person. Half tablets should have been provided but whole tablets had been sent. This should have been identified when these tablets were received and booked into the home as part of the provider's monitoring systems. We also saw records did not specify whether the stock held were full or half tablets. Without being clear about the exact quantity of half and full tablets held there was an increased risk of errors occurring. The deputy manager amended the monitoring sheet to record how many full and half tablets were in stock.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Some peoples' medicines were prescribed to take 'as required.' We identified that where 'as required' tablets where prescribed there were clear personalised protocols in place to identify when and how these medicines should be given. Staff understood and followed these protocols.

We checked some Medication Administration Records (MAR) and found them to be well completed. We also checked a number of boxed medicines against the MAR and found the stocks were correct. This assured us people had been receiving these medicines as prescribed.

The service was working with STOMP. STOMP is a national initiative which aims to prevent the over medication of people with a learning disability. Staff provided positive examples of how one person had particularly benefited from this initiative. Staff were planning a holiday for this person which they said would not have been possible before taking part in this initiative.

A new daily medicines handover had been introduced. We observed a handover. We saw staff counted all boxed tablets, checked MARs had been completed correctly and discussed issues and changes. Staff told us this system enabled them to identify and address errors more quickly. We saw a recording error was identified and addressed which demonstrated this system was effective.

Staff had a good knowledge and understanding of how best to support each person with their medicines. For example, one person needed additional encouragement and time. Staff talked to this person about their favourite football team which relaxed them and meant they were able to take their medicines. Where people didn't need additional support staff sometimes rushed people to take their medicines. Staff told us they wanted to ensure people got their medicines before the contractors arrived to fit the new flooring.

Our review of records, observations and discussions with people and staff led us to conclude there were sufficient staff to deliver safe personalised care. People told us there were enough staff to support them. One person said, "Staff are always here, if I need something I ask." One relative told us, "There always seem to be enough staff, there's always plenty of people around, when I go to visit, I've never gone in and not seen anybody." Another relative told us, "There's a few new staff and it is really well staffed at the moment, they

don't seem to be having any agency staff in which has been really good." Staff also told us sufficient staff were deployed to keep people safe.

Safe recruitment and selection procedures were in place to ensure staff were suitable to work with vulnerable people. Staff told us the recruitment process was thorough and they were not allowed to start work until all relevant checks had been made.

People told us they felt safe living at Rix House. One person told us, "I love it here, I am safe, I don't want to live anywhere else." A relative told us, "[My relative] is very safe and very happy they do look after him really well." Another relative said, "It's safe, trust me, if he wasn't safe they wouldn't be here." One relative described how they could tell their relative was safe from their relaxed body language and the positive way they responded to staff.

Staff had a good understanding of safeguarding procedures and spoke confidently about what actions they would take if they felt someone was at risk of abuse. The registered manager referred safeguarding concerns to the Local Authority safeguarding team and Commission. We found one recent safeguarding incident which had not been referred to the local authority or the Commission. From the information we hold about this service we know safeguarding issues are usually promptly referred to the relevant authorities. The registered manager assured us this was an isolated error and would not happen again. Following our inspection they made a retrospective alert.

The registered manager and deputy manager analysed all accidents and incidents. We saw evidence they had identified trends and taken action to reduce risks. There was a strong focus on identifying whether lessons could be learned from particular incidents to help reduce risk and re-occurrences. The registered manager discussed case studies and news articles in staff meetings to help increase staff awareness to particular risks and drive improvement to care practices.

Systems were in place to identify and reduce risk. Care records included personalised risk assessments and plans of care which informed staff how to deal with a range of scenarios. This included risks associated with behaviours that may challenge, moving and handling, choking and health conditions such as epilepsy and food intolerances. Staff knew people well and understood how to appropriately mitigate potential risks to people's health and safety. Risks and choices were balanced and designed to encourage and maintain independence. For example, one person had chosen to act against safety advice when bathing. Their capacity to make this decision was respected and a risk assessment was implemented to minimise risk.

Personal emergency evacuation plans (PEEPS) were in place for people who used the service. PEEP's provide staff with information on how they could ensure an individual's safe evacuation from the premises in the event of an emergency.

The was home clean, tidy and odour free. One relative told us, "The home is always clean, bedding is always fresh and clothes are always washed." Staff completed infection control training and infection control procedures were implemented. Personal Protective Equipment (PPE) including plastic aprons and gloves were accessible and used for appropriate tasks. One staff member had long painted nails which does not promote good infection prevention. We raised this with the registered manager who said they would remind staff of the correct procedures.

Good

Is the service effective?

Our findings

People's care needs were assessed and appropriate plans of care put in place. The service worked with a range of health professionals to develop effective care plans that adhered to recognised guidance. For example, one person was prescribed tablets to be given 'as required' when they became anxious. Staff had worked closely with the person's health facilitation nurse to develop a clear personalised protocol which outlined the exact circumstances for when this medicine should be given. Staff had a good understanding of this protocol and also told us they supported this person to attend regular reviews with their health facilitation nurse to monitor the use of this medicine and ensure the protocol remained appropriate to their changing needs. They told us involving the health professional enabled them to get specialist advice to ensure this medicine was used appropriately and in the person's best interest.

The registered manager put measures in place to ensure people received continuity of care when accessing other services. The registered manager volunteered to take part in the 'Red Bag Initiative' because they recognised people using the service may require additional support on admission to hospital. Each person had a red bag which was taken to hospital with them. It contained personalised documentation about the person's needs and important personal belongings. The scheme was in its early stages, however the registered manager was hopeful it would help improve the outcomes for people on admission to and discharge from hospital.

Staff completed an ongoing training programme which provided them with the skills to deliver effective care. Courses included epilepsy, nutrition and diabetes. Staff also received training in specialist topics such as Maybo; a specialised conflict management training programme which helped ensure staff worked to best practice guidance in managing behaviours that challenge.

A robust induction programme ensured staff developed the skills and knowledge to meet the needs of the people they cared for. The induction included competency checks and a training programme which incorporated the care certificate standards. The care certificate was introduced in April 2015 and is a standardised approach to the induction of new staff working in health and social care.

Staff told us they felt supported. There was a structured probation, supervision and appraisal system in place. This meant staff could discuss their responsibilities and development needs.

People received a balanced and nutritious diet. Staff involved people in developing menus and ensured foods were available to meet peoples' diverse needs. One person told us, "The food is really good. I never go hungry." Another person told us there was always "Lots of choice." The cook had a good knowledge about people's likes, dislikes and how to meet dietary needs.

Care files contained individualised information about people's nutritional needs. One person had food intolerances. We saw their care plan clearly described what this meant for them and contained additional guidance for staff to understand which foods the person could eat.

We saw evidence people's healthcare needs were being met. Where staff were concerned or had noted a change in people's health we saw they had made referrals to relevant health professionals. We saw the advice given by healthcare professionals was clearly recorded and followed. Records showed people had access to a range of health and social care professionals such as GP's, district nurses, dieticians, opticians, dentists and speech and language therapists.

One person said their relative often became anxious when visiting health professionals. They said staff managed to keep them calm and arranged for home visits to help reduce their anxiety. Another relative told us, "They have been brilliant with his health, they sort everything out." One person who lived at the home said, "When I didn't feel well they called the Doctor so I didn't worry."

People had health action plans in place. A health action plan helps support people with learning disabilities to keep healthy. Health action plans contained details of health appointments attended and what they needed to do to stay healthy. This meant people were effectively supported in access to healthcare services and received ongoing healthcare support.

Where required, we saw appropriate equipment such as hoists and bed sensors were in use. We saw people had been appropriately assessed for equipment and there were detailed care plans and risk assessments informing staff how to use it. One person's plan included photographs of the bedroom to show how it should look when equipment is fitted correctly.
The healthcare professionals we spoke with told us they had a positive working relationship with staff and said staff knew people who lived at the home well. One healthcare professional told us, "I feel they listen to any advice we give them and put our recommendations into practice. Staff are almost too on the ball as they call us out for little things which could potentially wait. But I suppose that's the best for the people living there to get things dealt with quickly. However, for us sometimes they need to have the confidence not to panic about the smaller things. "

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had a good understanding of both the MCA and DoLS and how it affected the care they provided. The registered manager had submitted DoLS applications to the supervisory body for most people who lived at the home. All of these applications were still awaiting assessment. Staff were proactive in monitoring the progress of these applications.

We saw examples to demonstrate staff worked within the wider framework of the MCA. Staff used personalised communication techniques to ensure people were given choices and to seek consent.

Where people lacked capacity to make specific decisions mental capacity assessments were in place. Staff demonstrated a good understanding of how and when to complete best interest processes and involved

independent advocates where appropriate.

Staff consulted and involved people in the design and decoration of the home to ensure it met their individual needs. New flooring was being laid in communal areas which people living at the home had chosen. People's bedrooms were personalised and people had been involved in choosing the décor of their room. There was a variety of communal spaces which were used for a range of activities and as private space to meet with family and relatives. Thought had gone into providing sensory environments which catered to people's individual needs. Staff had created a quiet lounge to meet the specific needs of a person who preferred a quieter environment. The outside area was accessible and used by people who lived at the home.

Good

Is the service caring?

Our findings

At our last inspection this domain was rated outstanding. While we saw examples of positive and highly caring practices during this inspection, we didn't see sufficiently strong evidence to demonstrate the provider had consistently ensured they continued to meet the exceptional and distinctive characteristics of an outstanding service.

Staff had a good understanding of the people they supported and used this knowledge to meet people's individual needs. Many staff members had worked at the service for several years so had developed strong relationships with people. Staff knew people's individual likes, dislikes and preferences. The information staff told us about people was reflected in people's care records. One relative told us, "Staff took the trouble to ask me about what he likes, what he didn't like and try to get to know him, which they have over the time." Another person explained how they did not know their relative particularly well. They told us staff had provided them with support and information during meetings with professionals to ensure a positive outcome for their relative.

We saw examples where staff put their knowledge into practice to deliver personalised care. For example, when one person became anxious we saw staff engaged them in a conversation about a topic which was really important to them. We saw this technique quickly calmed their mood. This approach was reflected in the person's behaviour management protocol.

People had access to staff who positively contributed to enhancing their experiences and developing their skills. The registered manager and provider implemented systems to enable people to build positive relationships with staff. People were actively involved in interviewing new staff and there was a strong emphasis upon people's views in the recruitment processes. One person told us they liked interviewing staff because it meant the service only employed people who "We will get along with."

People spoke about staff in positive terms. They said staff were kind, caring and friendly. One person told us, "Staff are lovely and kind. They are my friends, I like them all." People's body language and interactions with staff demonstrated they were relaxed and comfortable with them. One relative told us, "All of them, go over and above, if there is something they can do, and I mean outside his care package, they will do it, just to give them a lift or boost. They really are good with him. They interact with him, and I feel really care about him getting a good quality of life." Another relative said, "They can't do enough, we feel they care about us all."

Each person had a designated key worker who was responsible for developing and reviewing care plans and acting as the named contact for that person. Key workers were specifically matched to people's individual needs, experiences and personality. For example, where English was not people's first language the provider ensured they had a key worker assigned to them who was able to communicate in their preferred language. This helped ensure people and their relatives had key information about their care explained to them and also enabled the person's views and preferences to be understood and incorporated into care delivery.

Staff used a range of individualised communication techniques to ensure every person had a voice. Staff

continuously sought new and innovative ways to communicate with people and ensure everyone had the opportunity to express their views. The registered manager demonstrated a good understanding of evolving best practice and regularly reviewed and updated communication techniques used in the service. We saw examples where staff had sourced and implemented new technology and communication aids to help deliver a more personalised way of communicating with people. In doing so staff considered the individual needs of each person and sourced the best solution for each person. For example, where computer tablets were used as a communication aid we saw that each person had their own unique software which suited their individual needs.

The Registered Manager actively sought unique ways to help staff understand experiences from people's point of view. This was important because many people using the service could not verbalise their views. They had arranged for a dietary specialist to deliver a staff training session regarding the textures of different foods and how these impacted upon people's experiences.

Staff had a good knowledge of how to effectively communicate with each person whether that be through sound, touch, interpreting body language, technology and communication aids. This information was recorded in care plans to assist staff with a consistent approach. We observed staff communicating with people in their preferred way. One relative described how they had seen a significant improvement in the communication skills of two people. They told us both people had, "Come on so much more, since living at [Rix House], I can't believe they're both communicating much better since living here, staff work hard at understanding them."

We saw evidence that staff actively involved people in making decisions about the care and support they received. One person told us, "Staff listen to what I want. I feel listened to. They do what I ask." There were many formal and informal ways that staff ensured people were involved. Many people told us they liked the regular care reviews because this helped to drive personalised improvements to the care and support each person received.

People's relationships with their family and friends were respected. One person told us, "I have lots of friends. They can visit me whenever they like. It's my home." Relatives told us they felt welcomed whenever they visited. One person told us, "We are really respected as a family, when we arrive they always offer us a cup of tea. They are warm and friendly. It's always the same each time you go, everyone seems pleased to see you."

Relatives told us they felt involved and said staff were open and honest. One relative said, "They keep you involved with absolutely everything, which is how I like it. We go to meetings and talk about how things are going and how that impacts on his life, they always ask him what he wants, which is important." Another relative told us, "They keep you in the loop, and you always know what's going on." Another relative described how staff supported one person to visit a family member who had been ill. They said this had been really important for this person and their family. Whilst it was important for people to maintain relationships with people who were important to them, it was not always clear that it was each person's decision whether they wanted their family to be consulted and involved in their care. Staff involved independent advocates to help support decision making for people who did not have the capacity to make decisions themselves. However, this was usually for larger life decisions.

Staff treated people with compassion, dignity and respect. There was a positive focus on empowering people to be as independent as possible. Staff worked with people to set goals and aspirations to help people achieve the outcomes and skills they wanted. We saw staff had purchased a specialist kettle so people could safely make their own drinks. Another person had their own cupboard which contained foods

which met their specific dietary needs. This enabled them to maintain control over choosing their own snacks. The registered manager ensured staff focused upon supporting people to develop life skills that would enable people to move on from Rix House. Three people had recently been supported to move into their own home and which had a positive impact for them all. Relatives told us the registered manager had been open and honest about future plans for the service and had supported them to visit the private houses where people had moved. However several relatives told us they were worried about the future and whether their relative would adapt to independent living.

Staff had taken time to support people with their personal care. People looked clean and appropriately groomed. Regular visitors told us this was always the case. One relative said, "He's always clean and turned out perfectly we have, no concerns." Another relative told us, "It's the small stuff they do, without being asked. It's really comforting knowing he is well looked after."

Discrimination was not a feature of this service. We saw several examples to show how staff provided support to meet people's diverse needs including those related to disability, gender, ethnicity, faith and sexual orientation. People's individual needs were recorded within care plans. Staff had a good understanding of the specific needs of each person they supported.

Good

Is the service responsive?

Our findings

At our last inspection this domain was rated outstanding. Whilst we saw examples of positive practices during this inspection, we didn't see strong evidence to demonstrate the provider had consistently ensured they continued to meet the exceptional and distinctive characteristics of an outstanding service.

People received personalised care. Care plans were designed to ensure staff had the information they needed to meet each person's individual needs in a range of areas including nutrition, personal care and activities. Information on people's life history was also included to help staff understand the people they cared for. Care and support plans were regularly updated and reviewed when people's needs changed. This helped ensure responsive care.

People and relatives were involved in developing care plans. One relative said, "They have a big folder, that's all about him, including his quirks and everything, they gave me a copy last year which was nice. When I read it, they knew all about him, which is really good, including his medication and things like that, we were impressed they had taken the time to get all that information about him." The provider ensured staff were available who understood people's cultural needs so this important information was reflected in care plans for all staff to see.

The Registered Manager had a good understanding of the Accessible Information Standards and understood their responsibilities in relation to this. Care plans gave clear information about people's individual communication needs. Information about people's sensory and communication needs was also included in hospital passports to ensure health professionals also had access to this information. Disability distress assessment tools were in place. These identified different physical and vocal cues people displayed depending on their mood. This information was really important as many people using the service were unable to speak to tell staff how they were feeling. We saw staff adapted the way they communicated depending on people's individual needs. For example, we saw staff effectively interpreting one person's body language and facial expressions to recognise that this person wanted a drink.

Some people had behaviours that challenge. Staff had the information and skills to respond to behavioural changes. Staff were trained in conflict resolution and had access to clear protocols to enable them to appropriately respond to each person's individual behaviours. We saw examples where staff responded to people's changing moods, such as providing positive reassurance and redirection when people became anxious. Staff were calm and confident and clearly knew what action to take to appropriately support each person.

Some people had their end of life wishes recorded. These were very detailed and showed that an advocate and next of kin had been involved. The plan detailed the music the person would like played, things they wanted people to speak about along with the people they would like to speak at the funeral. For others there were no formal end of life plans in place. We saw this had been discussed with family members but they did not feel able to address this at the moment.

Staff supported people to engage in personalised activities. People told us they often played games and did arts and crafts. The registered manager told us staff identified some people were not benefitting from these group based activities. Staff had researched alternative sensory activities and developed their own sensory stories. These were interactive stories which staff acted out with props. They told us they could tell people benefitted from this more specialised approach because people became happy and excited when staff got out the sensory story props.

There was also a strong focus on community based activities. The service had its own mini-bus, which increased their flexibility to take people out. People were supported to attend day centres, go on outings and holidays. A relative told us, "They take him swimming, which he really loves, even his key worker will come in off rota to make sure he goes swimming, because she knows how much that means to him."

Staff respected people's interests and personal pursuits. Staff supported people to access local amenities and social groups which supported people's particular ethnic and cultural needs.

One person told us staff had supported them to attend the Houses of Parliament to discuss their concerns about costs for transportation costs for disabled people. They told us this topic was something they felt strongly about and they had been involved in a national campaign to raise awareness. They also told us they "Absolutely loved" helping staff to complete administrative tasks and were "In charge of answering the phones." Staff had purchased a specialist phone to enable them to do this. We could tell from their positive body language and how they spoke about performing this role that it was something they were proud of and that staff made them feel their work was valued and appreciated.

People told us they had no complaints about the service. One relative told us, "It's been a godsend has Rix house, I can't think of anything that I don't like about the place." Another relative said, "He is well looked after, I have a high opinion about the support he gets, staff go over and beyond." People told us the registered manager was visible and they felt able to approach them or any staff if they had a concern. One relative told us, "If I weren't happy, I wouldn't have a problem going in and speaking with [the registered manager], although I would probably be able to speak to any member of the staff, and it would be dealt with and I'm quite sure about that."

Staff respected people's views and responded to their concerns to improve the quality of care provided. People had access to a complaints procedure in easy read format. There had been no recent formal complaints. One person had been supported to complain to the owner of the building about the flooring in communal areas. Staff had supported them throughout and ensured they had the opportunity to explain the impact the current flooring had on them and others who lived at the home. The owner agreed to replace the flooring. Staff involved people in choosing what type of flooring they would prefer. On the day of inspection contractors came to fit the new flooring. Staff had considered how this may have a different impact on each person and where appropriate had arranged for people to attend various external activities to ensure people's safety and wellbeing.

Requires Improvement

Is the service well-led?

Our findings

During our previous two inspections we identified medicines were not always safely managed. During this inspection we found some new systems had been introduced but issues raised during previous inspections had still not been addressed, particularly around the management of topical medicines.

Following the inspection the Registered Manager assured us they were taking immediate action to address these issues. This included a full audit of the medicines management system by the provider's quality assurance team, developing clearer protocols for the management of topical medicines and more robust checks. We were not able to test the effectiveness and sustainability of these improvements as part of this inspection. Equally these issues had been raised through our previous inspection reports. Therefore the provider and Registered Manager should have taken action to address these issues prior to this inspection. As part of a robust quality assurance system the registered manager and provider should actively identify and address areas for improvement on a regular basis rather than wait for the Commission to identify shortfalls.

The Registered Manager told us they had done a lot of work with regards to the management of medicines and particularly around the management of topical medicines. They said the issues we identified may have arisen because staff had become "complacent". However, a well led service should be able to continuously sustain improvements.

Systems were in place to assess, monitor and improve the service and the quality of care provided. Checks were completed in key areas such as medicines, the environment, infection control and accidents and incidents. The area manager also visited the home on a monthly basis to inspect the service and ensure the registered manager had completed their role effectively.

Some aspects of the audit systems required improvement. We saw concerns regarding staff practices were not always dealt with in a prompt and effective manner. For example, the last two medicines audits identified staff were not consistently completing the reason for giving 'as required' medicines. This continued to be an issue at the time of this inspection. We also saw the last infection control audit identified some staff had long nails and were wearing nail polish. This also continued to be an issue on the day of our inspection. We also saw some audits were not sufficiently detailed. For example, the medicines audit did not include topical medicines. It was therefore not a comprehensive check of the entire medicines system.

The provider had an open and inclusive culture. People were consulted and involved in how the service was run. For example, we saw people were empowered to make key decisions such as choosing the décor of the home and which staff were recruited. The provider operated a People's Parliament which ensured people using the service were consulted about key changes and involved in driving improvements which were meaningful for people. We spoke with the current representative and they told us they enjoyed this role and felt their contribution was valued. Staff also told us the provider always put the view and experiences of people who use the service first.

Staff morale was good. Staff told us they would recommend the service as a place to receive care and as a place to work. Staff completed a satisfaction survey in January 2018 and an action plan was in place to address the areas raised. We saw the feedback at a local level was very positive. However staff said the provider needed to look at their broader policies to ensure they were functional. This was also reflected in staff's comments to us. Some staff told us the provider often introduced widespread policies which were not tailored to the specific needs of the service. They said the provider would benefit from involving local staff when developing their policies and procedures.

The registered manager was on holiday during our inspection. The deputy manager and team leaders were able to locate the majority of documentation we asked for. They also had sound knowledge of the topics and people we asked them about. This assured us the service would be effectively managed in the absence of the registered manager. We also spoke with the registered manager on their return to ensure they had the opportunity to contribute to the inspection process.

The registered manager was passionate about delivering good quality care. They had signed up to a number of local and national initiatives to help improve care quality. They were one of the first services in the region to sign up to the 'react to red' scheme. This is a pressure ulcer prevention campaign which educates staff about how to reduce the risk of skin damage. The registered manager provided examples of how their involvement in this campaign had ensured staff had promptly identified and responded to changes to people's skin. They had also signed up to the Commissioning for Quality and Innovation (CQUIN) framework which helped them to support improvements in the quality of services and the creation of new, improved patterns of care across the region.

People told us the registered manager was approachable, supportive and led by example. Staff told us the entire management team completed care shifts at least once a month and this helped them gain a direct insight into the needs of people who used the service and where staff may require additional support. One relative told us, "[Registered manager's name] is really good, if he's leaving after a shift he always comes in and says goodbye to everyone he's very hands on and not stuck in an office doing paperwork, he's definitely on the shop floor where everyone can see him and chat with him. We have a good relationship with him." Another relative told us they were "Really approachable, you can go and ask him anything. I think makes a good job of running the place."

We saw various examples to demonstrate staff worked in partnership with other agencies. For example, the registered manager had consulted the local authority to develop an easy read safeguarding policy and had also arranged for a specifically trained team to deliver a safeguarding training session to people who lived at the home which would be delivered in a fun and accessible way. They said they understood that many people who lived at the home may not fully retain information within the safeguarding policy so felt this interactive training session delivered by specially trained staff would help to ensure people had a good understanding of this important topic.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and complete records were not always maintained to ensure medicines were managed in a safe way.