Pennine Camphill Community Limited(The)

Pennine Camphill Community

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days on 5 and 10 December 2018. The last inspection was in March 2016 when the service was rated as Good with no breaches of regulation.

Pennine Camphill Community provides accommodation and personal care for up to 29 people with learning disabilities, some of whom are living with autism. It is a specialist residential college of further education and is situated on the outskirts of Wakefield. Accommodation is provided in five individually staffed houses. At the time of our inspection only two houses were accommodating students. The service is registered with CQC to provide accommodation and personal care as single package under one contractual agreement. CQC regulates both the living accommodation and the care provided, and both were looked at during this inspection.
At the time of this inspection there were 10 people using the service.

The service is required to have a registered manager. 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. There was a registered manager at the service.

People who used the service were referred to as students and this terminology is used throughout this report.

Students told us they felt safe at Pennine Camphill Community and relatives we spoke with appreciated the environment the service provided for students to be able to access the outdoors safely.

Safeguarding policies and procedures were in place but the service had not recognised some concerns as safeguarding issues and had not reported them appropriately. Risks assessments were in place but we found these were not always being used effectively. Positive risk taking was supported.

Some improvements were needed in the way medicines were managed and audited.

A health and safety group had recently been developed.

There were enough staff and volunteer co-workers to provide students with the support they needed and the provider had safe and effective recruitment and selection procedures in place.

Staff received training appropriate to their needs although evidence gathered during the inspection suggested staff would benefit from further training in MCA and DoLS.

Students were not always supported to have maximum choice and control of their lives and staff lacked an

understanding of the principles of the Mental Capacity Act, consent issues and people's right to make choices.

Students told us they enjoyed the food at the service although we did not see evidence of people being involved in menu planning. Some people followed restrictive diets although there was little evidence to support the reasons for this.

Students had confidence in staff and we saw caring, compassionate and friendly interactions between staff and students although language used by staff was not always respectful.

Although we saw evidence of some good practice, students' privacy and dignity needs were not always fully considered.

Students were encouraged to develop their independence and we saw examples of this. However, lack of choice in some areas did not fully support this.

Some improvements were needed in relation to documentation and practice to demonstrate a fully person-centred approach. Some care records had been developed in a person-centred manner but lacked evidence of student involvement.

A complaints procedure was in place and easy read information was available to support students to express any concerns.

Students had opportunities to engage in activities and new experiences of their choice.

Some routines within the service restricted student's opportunity to make lifestyle choices and there was little evidence of this being assessed on an individual basis.

People had confidence in the management team and they were open about their recognition of where improvements were needed. Some new systems had been introduced.

Systems for auditing the quality and safety of the service were not fully effective and the service had failed to make required notifications to the CQC of events within the service.

Systems were in place to support students transitioning between services.

We identified two breaches of regulations during the inspection. You can see what action we have told the provider to take at the back of the full version of this 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 consistently safe.

Safeguarding incidents had not always been recognised and reported as required.

Positive risk taking was supported but risk assessments were not always used effectively.

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

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service was not always working within the principles of the Mental Capacity Act. Students' rights and abilities to make choices were not always assessed and supported.

Staff received training and support appropriate to their roles.

Students enjoyed the food at the service but were not involved in menu planning.

Is the service caring?

Requires Improvement

The service was caring but some improvements were needed.

Staff were caring in their approach and students had confidence in staff.

Improvements were needed to fully support student's privacy and dignity needs.

Students' achievements were celebrated.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Students had opportunities to engage in activities and new experiences of their choice but some routines within the service restricted students' opportunity to make lifestyle choices and there was little evidence of this being assessed on an individual basis.

Some improvements were needed to demonstrate a fully person-centred approach.

Students knew who to go to if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People had confidence in the management of the service.

The management team had recognised that some improvements were needed and were addressing this.

Auditing of the service was not robust and had failed to identify issues that needed to be reported to CQC.

Pennine Camphill Community

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.

The inspection took place over two days on 5 and 10 December 2018 and was unannounced. On the first day, the inspection team consisted of three adult social care inspectors and a registration inspector. On the second day, the team consisted of two adult social care inspectors and a registration inspector.

Before the inspection we reviewed all the information we held about the service. This included past inspection reports and information notified to the Care Quality Commission by the provider. We also contacted other bodies including the local authority commissioning, police and safeguarding teams.

Before our inspection we sent 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. The provider returned it to us within the timescale requested.

During the inspection we looked at records relating to the provision of personal care and the running of the service. These included five students care records, medicines records, five staff files and other evidence which showed how the service was managed. We spoke with the principle, registered manager, care and business manager, two house managers and two co-workers. We spoke with seven students and two students' parents. We also spent time making observations around the service, including all communal areas, some bathrooms and some student's rooms.

Requires Improvement

Is the service safe?

Our findings

Students told us they felt safe at Pennine Camphill Community. One said, "I feel very safe, sometimes I go and sit on the bench and look over the lovely country and watch the animals." Another student said, "I feel very safe, if I didn't I would tell [Name of house manager]."

Staff we spoke with recognised different types of abuse and knew what to do if they thought someone was at risk. They said they would not hesitate to report suspicion of abuse and would escalate their concerns if they thought they had not been managed appropriately.

Any event staff regarded as a cause for concern was logged immediately by support staff on the electronic system. The registered manager told us they reviewed all incidents on a weekly basis, or more frequently if needed, with the care and business manager to decide if any referral needed to be made to the local safeguarding team. We saw evidence of these reviews. However, we noted within documentation, evidence of incidents which should have been reported to the local authority.

For example, we saw a complaint record written by a member of staff which said, 'While eating supper (Monday evening) (name) initiated a conversation with me, (person) listed three incidents in which (person) had been a victim. (Name) described in detail where (person) was hit/pushed, which session and who had done it to (person).' Another complaint record stated '(Name) felt quite angry and frightened because (other person) pulled (person's) arm and grabbed hard. (Person) knew what to do in this situation, (person) told (other person) "no" several times tried to walk away from (other person).' The record went on to say "(Person) understands that some students can be silly sometimes and that (person) has done the right thing. (Person) agrees that in future (they) will try and not be on (their) own when (other person) is around."

Neither of these events had been acknowledged as safeguarding concerns requiring referral to the local authority safeguarding team and neither had been reported, as required to CQC.

Risk assessments had been developed to support people's individual safety and well-being. Where a risk had been identified this was measured by looking at possible influencing factors, the frequency of the potential risk, the level of seriousness and the interventions needed to maintain the person's safety. Where risks were in relation to people's behaviour the outcome of the risk assessment determined if a behaviour management plan was needed.

However, we looked at records for a student with a physical condition which put them at risk and found little had been done to support their safety. The appropriate health professionals had been involved and had produced a risk assessment to support the student's safety. The risk assessment detailed actions that needed to be taken by staff at Pennine Camphill Community. We saw none of these actions had been taken despite the risk assessment having been in place for several months. We also noted the risk assessment was not held within the student's care plan for support workers to access. The house manager told us support workers did not need to have access to this information. This meant support workers may not have all the information they needed to help them support the student safely

Staff sought to understand, prevent and manage behaviour that the service found challenging. We saw care plans directed staff to support people in a way that minimised challenging behaviour triggers and what to do if behaviours occurred in specific, person centred ways. We saw documentation for a person who sometimes shouted when distressed, listed possible reasons, what staff should do initially and if behaviours continued to escalate. This aligns with best practice guidance.

Positive risk taking was supported. For example, following a period of support and guidance in relation to road safety, we saw one student had started to visit a local shop unaccompanied.

A system was in place for recording and reviewing accidents within the service. This meant the risk of the accident reoccurring was reduced.

Recruitment systems were in place to make sure staff and volunteers were safe to work with vulnerable people. This included police checks in the staff members' country of origin.

There were sufficient numbers of staff to support students with their care, support and social needs within the x individual houses. Each house had a manager, supported by permanent staff and volunteer co-workers who lived in the houses to provide care and support to students on a 24-hour basis. One house manager told us if students required help during the night they could go to a member of staff's bedroom to alert them.

The service's role in relation to medicines was clearly defined and described in relevant policies, procedures and training. The policy had been reviewed recently. Support staff who administered medicines had been trained to do so and their competency had been assessed by the registered manager. A system was in place to order medicines in time for when students needed them.

Medicines were stored securely in each house and only the house manager and deputy manager had access to them. Medicines were recorded and signed for on medication administration records (MARs) when they were delivered. Medicines stock, including tablets supplied and brought forward was recorded on each new month's MAR. Patient information leaflets had been retained for each medicine.

One student preferred to take medicines with yoghurt and this was recorded on their MAR. Staff explained this was not given covertly, without the knowledge or consent of the person receiving them, but rather they put the tablet into a spoonful of yoghurt themselves. MARs included photographs to help staff identify the correct person and details of any allergies.

No one living at the service received medicines covertly. MARs had been signed for each administration and there were no unexplained gaps. We checked the count of two medicines and one matched the expected count and one had one more tablet remaining than expected. The house manager explained they would consider this a medication error and record it in an online system (CPOMS) and inform the service manager. Later in the day they said they had investigated the issue and we were satisfied with their conclusion.

We discussed the possibility of students self-medicating as part of encouraging independence, and staff said this was not routinely considered, although one student currently self- administered some inhaled medications. We did not see a risk assessment had been undertaken for this. One of these medicines was prescribed to be taken when required. No protocol was in place for this, although staff and the student knew what it was for and when it would be needed. Staff supported the student to take this once daily on the advice of a relative. We spoke with a house manager and discussed the potential risks of taking advice from relatives rather than a pharmacist or GP. They agreed to follow this up.

Homely remedies are medicines for minor ailments that can be bought over the counter, such as Paracetamol for headaches or indigestion remedies. The service maintained a stock including Paracetamol to be given when required. No protocols were in place for these, contrary to the policy of the service and they were managed differently in each of two houses we visited. We brought this to the attention of the registered manager and principle.

We saw a medicines management audit tool was in place but noted the last audit was dated June 2018. The audit had identified some issues but the principle confirmed no further audit had been completed and we were therefore unable to establish if the issues had been addressed.

We recommend the service makes sure robust audits of medicines management are completed on at least a monthly basis to make sure issues are identified and addressed.

Staff and students told us what they would do in the event of a fire and said they had taken part in fire drills. We asked the registered manager if personal emergency evacuation plans (PEEPs) were in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. The registered manager told us they were not.

We recommend personal emergency evacuation plans are developed to promote the safety of students in the event of a fire.

The principle told us a health and safety group had recently been set up and showed us minutes from the first meeting along with an action plan to make sure the environment was safe. Although the action plan raised areas for improvement, we saw up to date certificates and records to show routine testing and maintenance of equipment was kept up to date. This included equipment used to provide care such as hoists, fire systems, and gas and electricity installations.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making particular decisions on behalf of people who may lack the capacity to make those decisions for themselves. These can be small decisions – such as what clothes to wear – or major decisions, such as where to live. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) part of the MCA. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. 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. A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.

Deprivation of Liberty Safeguards (DoLS) apply to Pennine Camphill Community because they are registered to provide accommodation to people.

We did not see evidence mental capacity assessments had been made for any other reason than the decision to live at the service. We saw applications for DoLS had been made for two students who had been assessed as lacking mental capacity to make the decision to live at the service. Records showed the students had not expressed any wish to leave but were unable to retain the breadth of information available about other options.

One application had been granted with no conditions attached. The other application had been applied for in collaboration with a social worker and followed up.

One student had an electronic door sensor in place on their bedroom door because they sometimes wandered at night. Staff said, "(person) is an adult and can make (their) own choices." We did not see their consent had been asked for or given or if a mental capacity assessment and best interest meeting had taken place to decide to implement this restrictive practice. These were not referred to in the DoLS application.

We saw parents had signed consents for such as photography and attending off site activity trips. When we asked staff why parents had signed consent forms for people who were able to make their own decisions they said, "Because parents believe they lack (mental) capacity."

One student's 'Education, health and social care plan' which is an NHS branded document developed with the funding authority stated the student, 'would not be able to make an informed choice as to what was in (their) best interests.' When we asked the registered manager if a DoLS application had been made for this student as a result of this, they told us they didn't agree with the statement. However, the registered manager was not able to show us any evidence of an assessment being undertaken of this person's capacity.

Staff told us about how some students were supported to eat a restrictive diet that was not required for health needs nor in response to allergies but was at the request of parents.

This meant staff at the service were not always working within the principles of the Mental Capacity Act. This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our conversations with students indicated they were not always aware of their right to make choices. For example, students told us about their bedtime of 9pm. One told us they had to go to bed at that time because, "They have to lock things up" and another said, "We need to go to bed then because we get up at 7am and would be tired." Another student told us how much they enjoyed watching television at home but couldn't do this at Pennine Camphill because they didn't have any televisions. When we asked if they could have one in their room they said they didn't think so. They also told us that after bedtime they had to stay in their room and hand in their mobile phone and tablet. One student told us they had a bath at 5pm when they had finished their jobs. When we asked if they could choose when they had a bath they said they could not.

We discussed issues about choice and students' right to make decisions about their lives with the principle. They agreed that work needed to be done to support students to make informed choices and, where this was restricted for good reason, this was managed appropriately through risk assessment.

Students told us they enjoyed the food and could ask for something else if they didn't like what was being served. We noted the menu in one house for the two days prior to the first day of our inspection showed the same meal at lunch and at tea time. For example, the meal for both lunch and tea time on one day was pasta bake and on the second day the menu said beef stew for both meals. Special diets were catered for. We did not see any evidence of students being involved in menu planning. When we asked a student if they could make themselves a snack or drink when they wanted one they said they could only help themselves to fruit and water.

We recommend the service assesses student's ability to make choices on a wholly individual basis to make sure students with the ability to make choices are not restricted by the needs of students who require a more structured approach.

Staff new to the service followed an induction programme. Staff without any experience of working in care followed the Care Certificate programme which is a nationally recognised set of standards for people new to care. Staff received training appropriate to their needs although evidence gathered during the inspection suggested staff would benefit from further training in MCA and DoLS. A system was in place to make sure staff received support through supervision and appraisal. The principal described how the system worked so that staff received support from their immediate manager.

Students lived in shared houses, each having their own bedroom and shared bathroom facilities. Communal areas were comfortably furnished and provided students with recreational facilities such as a pool table and projector for watching films. Houses were surrounded by gardens, farm land and all of the college facilities. There was a large hall where students could enjoy activities and parties.

Some of the language used suggested segregation within the houses. For example, staff referred in one house to the "boy's staircase" and the "girl's staircase." Staff told us this was just a way of identifying areas but a student we spoke with believed they could only use one of these staircases.

Documentation we reviewed showed students were supported to access healthcare professionals as the need arose. However, one student we spoke with was clearly suffering from a very heavy cold and was breathless on exertion. We saw from this person's records that they were susceptible to chest infections. They told us they did not feel well. When we asked the house manager about this person they told us they "knew what was best" for the student and they had arranged for their activities to be indoors that day. They told us the student's parent would be supporting them to see the doctor at the weekend (five days away). The student had not been given the option to stay in bed or in the house. After we raised the issue, the house manager told us they had arranged for a doctor's appointment that evening.

Requires Improvement

Is the service caring?

Our findings

All the students we spoke with told us that they liked being at Pennine Camphill Community and said the staff were caring. One student said, "The staff are kind and funny, they make me laugh." Another student said, "It's a wonderful place, I'm very happy here, we all get on" and another student told us, "It's like our own Hogwarts here, I really like it."

We spoke with the relative of one student who told us, "Our experiences of all the staff who work with my (relative), including the wonderful young people from abroad who come and give their services, is second to none." They said their relative, "Loves to go back (to Pennine Camphill Community) after the holidays" and "I couldn't wish for (relative) to be in a better setting." Another relative told us, "They have been marvellous."

We observed staff interactions with students during the day of our visit and saw people were treated with kindness, compassion and given emotional support. All of the students we spoke with demonstrated a trust in the staff supporting them.

There was little evidence that students were always supported to develop their independence by expressing their views, being actively involved in making decisions about their care, daily routines, aspirations and setting life goals. Students followed set daily routines, outside of college hours, from which there appeared to be little leeway. For example, students had jobs to do at set times, days for doing laundry and set bath and bedtimes. Staff also appeared to be rigid in their approach. For example, when we were speaking to a student who was not well, a staff member said to the student, "What are you doing? You have jobs to do."

We spoke with the principle about how they supported people in developing their independence. They agreed there was work to be done in this area and in making students aware of lifestyle choices available to them.

We saw some examples of action staff had taken to promote students' dignity. For example, a self-cleaning toilet had been provided for a student who had not managed to learn cleansing following the use of the toilet. Staff told us this had a very positive effect as being able to use the toilet independently had promoted the student's confidence and dignity.

Some of the language used within care documentation demonstrated a caring approach. For example, one student's care documentation described them as 'gentle and kind.' However, we found staff did not always use language which demonstrated a respect for students. For example, during lunch time, we saw a day student taken by a staff member from the dining room to stand outside. On their return to the room the staff member told other students this was because the person was "Being silly." We saw the word 'silly' used in other documentation including concerns about students' behaviours.

We saw some examples of how students' rights to privacy were not always respected. For example, we saw one person's weight chart on the back of a communal bathroom door. When we asked staff why this was there they told us "This is what we do; staff know where it is." We also saw one student's care passport,

which included very personal details, was pinned to the wall in their bedroom. This meant that anybody entering the room would be able to see these details.

We also noted none of the students' bedroom doors had locks on. When we asked a member of staff about this they told us it would not be safe for staff not to be able to access students' rooms if they became ill. We discussed with them the possibility of, following appropriate risk assessment, using door locks which meant the room was only locked from the outside, the lock released when the internal door handle was used and for which staff could hold a master key. The principle told us they were aware of this type of lock and had them in place on all exit doors in the newer buildings.
One student we spoke with said it would be good to be able to lock their door as another student came into their room at night. Another student, when telling us how much they liked the staff living in the houses said, "They can lock their doors; I don't have a key for my door." Although students had a lockable cupboard in their rooms, a member of staff told us the keys for two of these were held together and placed on a shelf on a corridor outside the student's rooms at night. This meant that both students concerned, and anyone using the corridor, would have access to both keys. On the second day of our inspection we were informed by staff that the keys were now being left in the student's own room.

Although the service predominantly followed the Christian faith, staff told us students of other faiths were welcomed and would be supported to follow their beliefs.

A parent of one student told us, "It is wonderful to see the friendships (person) has developed for the first time in (their) life. This is truly transforming." One student told us about a friendship they had developed with another student and how they enjoyed spending time in their room, playing draughts together.

We saw a 'star of the week' scheme was in place. The principle told us this was so that staff remembered to celebrate students' achievements. For example, students attending a dance session which they had been unsure about, using different equipment, displaying a positive attitude and achieving paid employment had all been celebrated with a little ceremony to which student's parents were invited.

Requires Improvement

Is the service responsive?

Our findings

Staff knew people well and supported them in a way which met their needs. However, we found care and support documentation was not maintained or used in a way which would support a fully person-centred approach.

Each student had a 'Care Passport' which gave a brief overview of their needs and the support they needed to meet them. Care passports had been developed with a person-centred approach and were written from the point of view of the student. However, we found these did not include all the information provided in the 'Education, health and social care plan.' This provided a detailed overview of the student, their personality, support needs, preferences and health care needs but was only available to senior staff. For example, one student's Education, health and social care plan gave good details of a physical condition and included clear information about how this condition should be managed, particularly in relation to their diet. This was not explained clearly in the care passport which meant staff providing day to day support may not have the understanding they needed to support the person in the most effective way. We also found information about student's behaviours and support needs in this area were detailed in the Education, health and social care plan but had not always been included in the care passport or behavioural support plan.

Staff told us documentation was kept in different areas of the service, for example, some in the administration department and some in the house where the student lived. We were assured that, in an emergency, staff would be able to access all documentation either on the electronic system or in paper form.

The registered manager and principle understood our concerns in relation to care documentation and agreed some reorganisation may be beneficial.

One of the care and support files we looked at included a picture folder in which photographs of the student's family were detailed with who the people were and what they meant to the student. This demonstrated staff recognised the importance of people's families in their lives.

Our discussions with both staff and students demonstrated to us a very structured regime which did not always support a person-centred approach. Students told us they had set bed times, getting up times, bath times and times to complete their chores. One student told us that if they could not sleep at night they would have to read their book as they were not allowed to leave their bedroom. We saw documentation which supported this in the incident file where the house manager had written, 'Just after 8.30pm (name) walked into my apartment and stood in the living room. I very firmly told (person) to get out, (name) didn't respond and kept staring at me. I led (person) outside and into (their) bedroom, spoke to (them) very firmly to go to sleep and not get out.'. The report did not include any information about the person being asked if they were upset or unwell or needed anything.

We understood from our discussions with staff and parents how some students needed a structured routine; however, we recommend this need is assessed on an individual basis.

We saw student's bedrooms were mostly personalised. One told us "The support workers decorate our rooms, we get to choose the colours." Another student told us, "I like my room, I have all my things here." However, we noted one student's room did not meet their particular physical needs and no adaptations had been made to support these needs.

Students told us they had more opportunity to make choices about how they spent their time at weekend. One student said, "At weekends we can get up later, breakfast is something like 9 or 10 o'clock, we can choose what we do; we go to Leeds or Wakefield shopping." We also saw how, after a student had expressed an interest in swimming, a small group were supported to regularly visit a local pool.

Students were able to choose a range of activities within the service. One student told us about the large hall where they had parties and social gatherings such as barbeques. Another told us, when we asked if they could go out at night or watch television programmes of their choice, "No, we are not allowed a television; we have movie nights sometimes after we have done our jobs."
Staff told us some students did go out together to local amenities and could, if they wished, visit the local pub but no alcohol was allowed at the service.

At the time of our inspection, students were engaged in making Christmas decorations for their upcoming fair. One student told us they had just had a 'Candlemas' event and said, "It was lovely."

We spoke with the parent of a student who had been supported to undertake paid work experience. They told us they thought this would never have been possible without the support of staff and said how it had really helped with the student's confidence and self-esteem.

Students were provided with an easy read 'Compliments, comments and complaints' pamphlet which told them that staff wanted to know what they thought. The pamphlet included a photograph of the principle to help students to know who to go to. It also included telephone numbers of other people they could contact. One student showed us easy read cards they could fill in anonymously and put in a post box in the house but said they could also just speak to someone. When we asked if they had ever needed to complain they said, "No, I'm always happy."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place at the service. The registered manager was line managed by the college principle. We spoke with both during our inspection. All of the people we spoke with expressed confidence in the management team at the service. One parent told us, "I would rate them very highly" and "They should be congratulated on all they have done for (person)."

The principle told us they were relatively new to the position and had recognised that some improvements were required at the service to make sure students received the best care and support in an environment that was safe and met their needs. The principle demonstrated an openness to the inspection process and was clear about how they would like the service to develop.

The principle told us they were aware that auditing systems within the service were not fully effective and they told us about how they planned to develop these systems. This included a recently developed health and safety group. We saw minutes of the first meeting of this group which detailed a number of improvements required within the service. Actions had been identified along with the person responsible for making sure the action was taken. We saw the principle had already introduced new documentation for improved auditing of safety within the service.

The principle told us that auditing of the service in general needed to be improved to make sure any issues were identified and addressed. They confirmed to us that regular auditing of the houses in which students lived was not completed and we did not see any audits of care and support records. An example of where current systems had not been effective was in relation to auditing medicines management. An audit dated June 2018 had identifies issues but we did not see any evidence of these being addressed or a further audit completed. The principle confirmed to us this had not been done.

We were concerned that the overview of events that happened within the service had failed to identify safeguarding and other issues affecting the service, including a break-in which had included police involvement. These had not been reported appropriately. This included a failure to report to the Care Quality Commission which is a legal requirement.

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

We saw systems were in place for people to give their views about Pennine Camphill Community and information provided to students and their relatives advised the service appreciated people giving their views.

Staff meetings were held and staff told us they had confidence in the management team and were supported by them.

We saw 'House meetings' were held, but these were for staff and did not involve any of the students living in

the house.

We saw systems were in place to support students ready to move on from Pennine Camphill Community. The service worked with students' families and involved professionals during this process. The registered manager told us about students who had been supported to move on to more independent living and how they assisted students, who would continue to need additional support, to find a service to meet their needs.

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 11 HSCA RA Regulations 2014 Need for consent Staff at the service were not always working within the principles of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for auditing the service were not robust and incidents had not been reported as required.