CARE AND SOCIAL SERVICES INSPECTORATE WALES

Care Standards Act 2000

INSPECTION REPORT
CARE HOMES FOR YOUNGER ADULTS

Conway House

6 Penylan Road,
Roath,
Cardiff
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DATE OF PUBLICATION

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Registered provider:	Ocean Community Services Limited Responsible Individual (RI) Steve Bartley
Registered manager:	Steven Raymond Watkins
Number of places:	8
Category:	Care Home - Younger Adults Mental Health and Learning Disability
Dates of this inspection from:	18th January, 2008 **to:** 2nd July, 2008
Dates of other relevant contact since last report:	Announced inspection 2nd July, 2008 0950-1435 hours
Date of previous report publication:	
Inspected by:	April Phillips

INTRODUCTION

This report has been compiled following an inspection of the service undertaken by the Care and Social Services Inspectorate for Wales (CSSIW) under the provisions of the Care Standards Act 2000 and associated Regulations.

The primary focus of the report is to comment on the quality of life and quality of care experienced by service users.

The report contains information on how we inspect and what we find. The report is divided into distinct parts mirroring the broad areas of the National Minimum Standards.

CSSIW's inspectors are authorised to enter and inspect regulated services at any time. Inspection enables CSSIW to satisfy itself that continued registration is justified. It also ensures compliance with:

- Care Standards Act 2000 and associated Regulations whilst taking into account the National Minimum Standards.
- The service's own statement of purpose.

At each inspection episode or period there are visit/s to the service during which CSSIW may adopt a range of different methods in its attempt to capture service users' and their relatives'/representatives' experiences. Such methods may for example include self-assessment, discussion groups, and the use of questionnaires. At any other time throughout the year visits may also be made to the service to investigate complaints and to respond to any changes in the service.

Readers must be aware that a CSSIW report is intended to reflect the findings of the inspector at a specific period in time. Readers should not conclude that the circumstances of the service will be the same at all times.

The registered person(s) is responsible for ensuring that the service operates in a way which complies with the regulations. CSSIW will comment in the general text of the inspection report on their compliance. For those Regulations which CSSIW believes to be key in bringing about change in the particular service, they will be separately and clearly identified in the requirement section.

As well as listing these key requirements from the current inspection, requirements made by CSSIW during the year, since the last inspection, which have been met and those which remain outstanding are included in this report. The reader should note that requirements made in last year's report which are not listed as outstanding have been appropriately complied with.

Where key requirements have been identified, the provider is required under Regulation 25B (Compliance Notification) to advise, in writing, the appropriate regional office of the completion of any action required by CSSIW.

The regulated service is also responsible for having in place a clear, effective and fair complaints procedure which promotes local resolution between the parties in a swift

and satisfactory manner, wherever possible. The annual inspection report will include a summary of the numbers of complaints dealt with locally and their outcome.

CSSIW may also be involved in the investigation of a complaint. Where this is the case CSSIW makes publicly available a summary of that complaint. CSSIW will also include within the annual inspection report a summary of any matters it has been involved in together with any action taken by CSSIW.

Should you have concerns about anything arising from the inspector's findings, you may discuss these with CSSIW or with the registered person.

Care and Social Services Inspectorate Wales is required to make reports on regulated services available to the public. The reports are public documents and will be available on the CSSIW web site: www.cssiw.org.uk

SUMMARY

Conway House Care Home is registered with CSSIW to provide accommodation together with personal care to eight younger adults (aged 18-65 years) in the category of Mental Health and/or Learning Disability. The Registered Provider is Ocean Community Services Ltd. and their Responsible Individual (RI) is Stephen Bartley. The Registered Manager, subsequently referred to as the Manager, is Steven Watkins.

The home is a large, converted commercial premises situated in a residential area near to Cardiff city centre, but with many local facilities including shops, supermarkets, post office, banks, restaurants, cafes, and pubs. There were high standards of décor and cleanliness throughout the home.

CSSIW proportionate approach to inspection was used for this inspection episode, which aims to give emphasis to the service users' experience of the quality of service they receive. It also gives Registered Persons the opportunity to look at the service they provide and make their own observations on how they think their care home is meeting the regulations via a signed self-assessment form (SAF). This document also provides CSSIW with the Registered Persons' views of the strengths of their service, areas that require further improvement/development, and the future plans for the service. As part of this inspection process Conway House supplied a signed self-assessment statement and associated documentation, and the Registered Persons co-operated fully with the regulatory process.

From analysis of the self-assessment form and documents provided with it, the methodologies decided on for this inspection episode were:

* discussions with service users
* discussions with staff
* examination of service user, staff and other required records
* inspection visit including consideration of the premises and facilities
* discussion and correspondence with the Registered Persons.

As staff and service user questionnaires had been used during the previous inspection episode, they were not sent again. They had been sent to all four service users at the time and thirteen staff, and one service user (25%) and 3 (23%) staff had completed and returned them. Information from the staff questionnaire responses is used where appropriate throughout this report. For reasons of confidentiality, detailed responses to the service user questionnaire are not given as there was only one respondent.

The Manager was involved throughout the inspection visit.

The inspector would like to thank service users, staff, and the Registered Persons for their assistance with the completion of the inspection for this period.

CHOICE OF HOME

Inspector's findings:

Information

There is an up-to-date Statement of Purpose and a Service User's Guide which now both contain all the information required by Regulations 4 and 5, and there were signed statements that service users had received copies of the Service User Guide on their files. There was also a copy of each in the entrance hall.

Needs Assessment

Prospective service users' individual aspirations and needs are assessed as had previously been demonstrated in the service user records examined, and new service users are admitted only on the basis of a full assessment undertaken by OCS clinical assessment team. Their assessment report is then sent to the Manager to agree that the home can meet the assessed needs.

Rehabilitation and therapeutic needs are assessed by registered health professionals and any potential restrictions on choice, freedom, services or facilities are discussed with the prospective service user and form part of the Service User's Plan. A 'Pre-admission Risk Assessment' document examined on this inspection visit raised concerns which are discussed under 'Risk Taking' below. Family and carers' interests and needs are taken into account, subject to the service user's agreement.

In response to a previous requirement that service users sign their needs assessments, the Registered Persons had responded that service users sign the revised care planning documentation which also has a section for service user's comments. Sample documents to demonstrate this had been provided but only one of them ('Care Plan') had space for service user comments and signature. The other documents ('Care Plan Evaluation and Record Sheet', 'Client Risk Assessments' 1-3) were only signed by the professionals involved with no evidence of any service user involvement. The Manager said that although there was no space for service users to sign these documents, they did sign the actual sheets.

Meeting Needs

Information provided indicated four service users with an average age of 29 in a range of 22 to 41, and an average length of stay of 1 year 1 month in a range of 4 months to 2 years 1 month.

Following a previous requirement under Regulation 14.-(1)(d), the Manager does now write to prospective service users to confirm that, having regard to the assessment, the care home is suitable for meeting their needs in respect of health and welfare, and he had provided a copy of a sample letter for this. This was also evidence on the service user's file examined.

Subsequent to moving in there are formal, multi-disciplinary reviews at three months and six months. The Manager had said that if it were felt that the home were not able to meet the service user's needs, alternative arrangements would be made. Service users are

invited to these review meetings, but do not always choose to attend,

Some specialised services such as occupational therapy and psychiatry are provided by professionals employed by the company. Other services are accessed via community based professionals.

The Registered Persons state in the SAF and the Statement of Purpose that service users are encouraged to celebrate major religious festivals of their choosing and that they will be supported to practise the religion of their choice and to attend any religious service they choose.

Relevant training is provided to ensure that staff individually and collectively have the skills to meet the assessed needs of the service users.

The Registered Persons stated in the SAF that all service users' first language was English and that there were no communication problems.

Trial Visits

Service users visit the home before moving in and overnight stays are offered. Arrangements for this are made in accordance with individual service users' wishes. Visits can include meeting the other service users and staff, having meals with them, having tea/coffee, and being shown around the local community.

The Manager said that service users move in on a three month trial basis and that there are monthly evaluations of the Service User Plans to ensure that the home is able to continue to meet their needs.

Contract

There were copies of service agreements between the company and the placing authority, and, following a previous requirement, there was also a statement of terms and conditions for signature by the service user and a Registered Person as required in NMS 5.5 and an example was seen on the service user file examined.

Requirements made since the last inspection report which have been met: Not applicable

Action required	When completed	Regulation number

Requirements which remain outstanding: Not applicable

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection: Not applicable

Action required	Timescale for completion	Regulation number

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.

INDIVIDUAL NEEDS AND CHOICES

Inspector's findings:

Service User Plan

All respondents to the staff questionnaire had said that they had access to the individual Service User's Plans and that they felt confident that the care provided was in line with the Plans. One of the respondents had felt that service users were always involved with decisions about the care they receive, one had felt they mostly were and one had felt they sometimes were. All had described the standard of care given by staff as 'Very Good' or 'Good'. None of the respondents had had any concerns about the care provided but all had said that, if they did, they would be able to discuss them with managers.

The service user file examined (for a service user who had moved in since the last inspection visit) was very well organised, clear and comprehensive. In addition to basic details and a likes and dislikes form, the Service User's Plan consisted of six separate, detailed, numbered care plans in respect of each assessed need, detailing action to be taken and by whom. Each page of the original plan was signed by the service user and the staff member, and there were also daily and monthly review records.

Risk assessment and management is an integral part of the plans but there were also detailed risk assessments on a form with headings including: verbal aggression; physical aggression; self-harm; damage to property; inappropriate sexual behaviour; substance misuse; unauthorised leave; and personal vulnerability. Each aspect, where relevant, is assessed as low, medium or high risk with the risk management action and the person responsible detailed. There is now space on these forms for the service user to sign as well as the consultant psychologist and the Manager. For details of the risk assessment seen on the service user file examined and issues arising, see 'Risk Taking' below. Where there was an Occupational Therapy Agreement this was signed by the occupational therapist and the service user.

It was suggested that it might be helpful if the Service User's Plans were cross-referenced to the relevant parts of the risk assessments and initial needs assessments, in order to demonstrate how the Plan related to each assessed need, particularly as the various documents did not have consistent headings.

The file examined contained contact sheets for GP, optician, dentist, physiotherapists, psychologists, psychiatrists, speech and language therapists which were completed as appropriate. There was also a separate section for occupational therapy with detailed records. The keyworker was named in the service user's file.

Decision Making

Staff provide service users with the information, assistance and communication support they need to make decisions about their own lives, and examples of this were observed on the inspection visit. The Manager had previously said that he ensures that staff respect service users' rights to make decisions, and that rights are limited only through the assessment process, involving the service user, and are recorded in the individual Service User Plan. A previous requirement regarding ensuring that any limitations to a

service user's freedom are recorded in their Service Users Plans, had been met according to a compliance notification from the Registered Persons. See details of issues arising from the risk assessment of one service user discussed below under 'Risk Taking'.

The Registered Persons stated in the SAF and the Statement of Purpose that service users are encouraged to access external advocates to help them make their voice heard and that a list of advocacy services is available to all service users, and that the home is committed to building a partnership with an appropriate advocacy agency.

The Manager said that the home does not currently act as appointee for any of the service users. Three service users control their finances, two with support from their parents, and one, at his request, is supported by the home and the Manager said that this is now documented in his Service User's Plan.

In response to a previous requirement, the Registered Persons had notified CSSIW that records of service users' benefits and finances are now on file at Conway House.

Participation

Service users are consulted on and participate in all aspects of life in the home and the Registered Persons stated in the SAF that service users are encouraged to attend service user meetings or to discuss issues as a group as well as on a one to on basis.

The Manager said that service users are currently only involved in a small way with unit policies, but still not in the production of company policies. He had previously stated that the company was looking into forming a policy group and he had hoped that service users would be involved with the group. Since then, the group had been formed but does not include any service users.

Risk Taking

Service users are supported to take risks as part of an independent lifestyle.

In response to a previous requirement that service users sign their risk assessments, the Registered Persons had responded that service users sign the revised care planning documentation which also has a section for service user's comments. Sample documents to demonstrate this had been provided – see above under 'Needs Assessment' for comments.

The 'Pre-admission Risk Assessment' form examined, and completed by the OCS consultant psychologist, was for a male service user and had his name on it, but the content referred to a female service user by name in one place, and by reference to "her" in another. "No history" had been entered under most of the standard headings in the 'Identified Risk Behaviour and Evidence' column, and the Manager confirmed that this was the case and was as had been discussed at the pre-assessment meeting. However, in the column for 'Risk Management Action', actions were detailed that inappropriately restricted the rights and freedoms of someone with no identified risk in the specific areas, for example: to be accompanied in the community 1:1 at all times ('Theft'; 'Substance Misuse'; 'Unauthorised Leave') furniture such as wardrobes to be fixed to the wall/floor ('Damage to Property'); all gifts to be handed in to shift leader/managers ('Theft';

'Substance Misuse'); no access to lighters/matches in the house; no accelerants; supervised access to toiletries that could be accelerants e.g. aerosols ('Fire Setting'); male staff not to work with (female service user's name) ('Allegations'); contract of expectation ('Non-compliance'); and relations to be informed of protocol ('Theft'). The last example could also constitute a breach of confidentiality.

The Manager said that these restrictions had not been discussed at the pre-admission meeting but had been typed up later. However, both the Manager and the service user had signed this assessment document. He further stated that the inappropriate restrictions were not actually being implemented. This raises further questions around staff not reading documents and service users signing documents they have not read and/or had explained to them, and also staff not following the risk assessments that are in place. The Manager said that he would address all these issues and also that the service user's plan was being reviewed the following week and that he would discuss the issues at the review meeting and ensure that an appropriate risk assessment was put in place.

The issue regarding restriction of rights for one service user that impinged on the rights of another service user was discussed. For example, if one service user's plan had an assessed need for knives and other sharp implements to be locked away, other service users without this assessed risk should sign their agreement to this happening, and it was agreed that it would be more appropriate for them to sign the other service user's plan, rather than it appear as an identified risk on their own.

The company has a missing persons policy to ensure that staff respond promptly to unexplained absences of service users according to written procedure, a copy of which was seen in the home.

Confidentiality

A 'Confidentiality and Disclosure of Information Policy' had previously been provided but had not included arrangements for confidentiality of information about staff, nor arrangements for service users/staff to access their information. OCS stated in the SAF that this policy had been reviewed since the last inspection.

Responses to the staff questionnaires had indicated that there were good arrangements for keeping information about people in the home confidential.

Requirements made since the last inspection report which have been met: Not applicable

Action required	When completed	Regulation number

Requirements which remain outstanding: Not applicable

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number
In order to ensure compliance with Regulation 13.-(7) and that no unnecessary restraints are put on service users, the Registered Persons must ensure that risk management plans are appropriate to service users' needs and that they are read and understood before being signed by the Manager and the service user and implemented by the staff.	02/07/08	13 (7)

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.

LIFESTYLE

Inspector's findings:

Personal Development

Service users have opportunities for personal development and this had been previously evidenced in the files examined.

Service users in treatment and recovery programmes receive professionally validated interventions, counselling and therapy.

Education and Occupation

The Statement of Purpose states that staff aim to enable service users to be given the same opportunities as their peers in the local community, and will provide appropriate support for this.

Community Links and Social Inclusion

The Statement of Purpose states that there are opportunities for service users to develop their social and life skills. The home has access to the company's occupational therapist to help with this. The activities are planned and encouraged and are based on individual, structured assessments and programmes. Examples of service users' weekly activities programmes were previously provided and included activities within the home and in the community, but also many open sessions for service users to choose their activity.

The Manager said that the home has its own transport for service users, but that service users are also encouraged to use public transport with support as necessary.

Leisure

There is a company based occupational therapist employed to complete and regularly monitor client-centred assessments which include interests and activities, and she spends two days a week in the home. The Registered Persons stated in the SAF that service users are consulted about their social interests and activities via activity checklists, service user meetings and their activity plans.

Staff also support service users to take part in a variety of activities both inside and outside the home. One service user chooses not to have a structured programme of activities but prefers to decide what to do each day, and staff encourage and support him with this on a daily basis.

Relationships

Service users are helped to maintain their existing personal and family relationships, and are encouraged to develop these as appropriate.

Daily Routines

The Manager said that all of the service users had keys to their bedrooms and that they

were having a different lock fitted to meet the needs of one service user. The Manager said that it is common practice for staff to knock service users' doors and wait for a reply before entering, unless the service user doesn't reply when two staff would enter.

Only staff have fobs for the magnetic lock on the front door. Service users are still unable to independently unlock the front door but the Manager said that there is no problem with staff doing this at the service user's request. There was no evidence in service user files of this having been risk assessed. The Manager said that they had been discussing the possibility of having a different type of lock fitted to the front door so that service users could have keys, but said that he did not think that there would be a problem with service users having fobs for the present lock. It was suggested that the Manager should issue service users with fobs for the front door unless this had been contra-indicated in an individual risk assessment.

Staff do not open service users' mail, the Manager said that it is handed directly to them.

Staff use service users' preferred form of address which is recorded in the individual Plan, and this was observed during the inspection visit.

Staff talk to and interact with service users, not exclusively with each other, and this was observed during the inspection visit.

Service users' responsibility for housekeeping tasks is specified in the individual Plans.

Meals and Mealtimes

All respondents to the staff questionnaire had thought that the food for the service users was very good (2) or good (1).

The Manager said that service users are supported to help plan, prepare and serve meals. He said that lunchtimes varied according to service users' activities, but that they usually had the evening meal as a group.

The Registered Persons stated in the SAF that arrangements to meet special dietary needs include a dietician employed by OCS, and advice sought from the NHS diabetes nurse. There were no service users with special dietary needs at the time of completion of the SAF or the inspection visit, just guidance on healthy eating including for a type 2 diabetic whose diabetes is controlled with tablets.

Individual records of food are kept on a daily basis with details of each meal eaten and these were seen on the inspection visit.

Requirements made since the last inspection report which have been met: Not applicable

Action required	When completed	Regulation number

Requirements which remain outstanding: Not applicable

Action required (previous outstanding requirements)	**Original timescale for completion**	**Regulation number**

New requirements from this inspection:

Action required	**Timescale for completion**	**Regulation number**
In order to respect the dignity and rights of service users as required in Regulations 12.-(4)(a) and 13.-(7), and NMS 16.3, the Registered Persons must, unless contra-indicated in an individual risk assessment, issue service users with fobs for the front door lock.	31/07/08	12 (4) (a) 13 (7)

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.

PERSONAL AND HEALTHCARE SUPPORT

Inspector's findings:

Personal Support

Service users receive personal support in the way they prefer and require. The Registered Persons stated in the SAF that service users' preferences of male or female staff providing personal care are met through risk and suitability/compatibility assessments, individual discussions with service users regarding their preferences, and a gender mix of staff.

The Manager had previously said that service users can choose how often to have a bath or shower unless otherwise indicated in their plans, for example being restricted to 2-3 times daily.

Healthcare

Service users are registered with local general practitioners and receive additional, specialist support and advice as needed and identified in their Plans from professionals such as physiotherapists, occupational therapists, psychologists, and psychiatrists, some from the community, some employed by the company.

Medication

The Manager said that service users are encouraged to administer their own medication on a risk-assessed basis but that currently none of them does this. Of the three service users who are on medication, one does not want to administer his own, one is working towards administering his own and the Manager said that for the third it is not appropriate at present. Most medication is administered by staff and stored in a locked metal cupboard fitted to the wall in the office. Individual medication records are kept but the system was not checked on this occasion.

The medication policy in use still requires some amendment. It does now include the procedures for administering and recording controlled drugs but states that if a member of staff is working a lone shift, a second member of staff should verify the administration at the beginning and end of the shift. This is not acceptable. If controlled drugs are in use there must be two staff present at the time of the administration to witness the administration and to check the balance of the medication at the time.

Also, the medication policy does now include information regarding invasive procedures, but states that vaginal administration can be undertaken by trained support staff. This should not happen. The only invasive route for medicines administration by support staff for which there is an accepted procedure is the emergency administration of rectal diazepam. Support staff should not undertake any other invasive procedure including for blood tests for service users with diabetes and any other injections for these service users, or any medicine requiring administration via the vaginal route. The emergency administration of rectal diazepam (when an ambulance has been called but is delayed in arriving) should only be undertaken if the following safeguards are in place: staff must be trained to do this; the health professional providing the training must assess the

competence of the staff member and sign in respect of this and that they (the health professional) retain accountability; the staff must be named in the individual Service User's Plans and samples of their signatures and initials kept on the file; and the appropriate insurance must be in place. The OCS procedure only includes that staff should be trained. Without the other safeguards staff are vulnerable to prosecution. The Manager confirmed that the current service users at Conway House do not need any invasive procedures.

Evidence was seen in training records of accredited staff training in medicines administration being provided in three units via a programme jointly produced by the pharmacy group and Keele University.

Requirements made since the last inspection report which have been met: Not applicable

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number
In order to comply with Regulations 12.-(1), 13.-(1)(b) & 13.-(2), the Registered Persons must, from now on, ensure that only health professionals undertake invasive medical procedures with the exception of the emergency administration of rectal diazepam under the conditions described above.	18/06/07	12 (1) (a) 12 (1) (b) 13 (1) (b) 13 (2)

New requirements from this inspection: Not applicable

Action required	Timescale for completion	Regulation number

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.

STAFFING

Inspector's findings:

Roles

Staff are encouraged to know and support the main aims and values of the home which are stated in the Statement of Purpose and reflected in the home's policies and procedures, copies of which are available in the office.

Two of the respondents to the staff questionnaire had said that they were aware of the Care Council for Wales' (CCW) Code of Conduct. One had not replied.

Volunteers are not used and this had been confirmed by all respondents to the staff questionnaire.

Qualities and Qualifications

The home still does not meet the National Minimum Standard of 50% of care staff holding NVQ level 2 in care or a similar qualification approved by the Care Council for Wales. This has been a national minimum standard since 1st April 2005. The Registered Persons indicated in the SAF that only one of the eleven staff (9%) had NVQ Level 2. This had since improved and at the time of the inspection visit six of the thirteen staff (46%) had an NVQ qualification - the Deputy Manager had gained NVQ Level 4 (pending verification), a Senior Support Worker had gained NVQ Level 3 and a further four staff had NVQ Level 2.

None of the remaining staff was registered to undertake NVQ but the Manager said that three of them had unsatisfactory sickness levels, and the other four were still in their probationary periods. The company policy is that staff are referred for NVQ training following successful completion of their probationary period and providing sickness and absence levels are satisfactory and there are no current disciplinary actions. The company then prioritises training provision for settings that have not attained the 50% target.

Staff Team

Respondents to the staff questionnaire had felt that the staff worked well (2) or average (1) as a team.

At the time of the inspection visit, the staff team consisted of a Deputy Manager, three Senior Support Workers, one trainee Senior Support Worker, six Support Workers, and two trainee Support Workers. The Manager said that they were all full-time and they had an average age of 30 (for the twelve staff for whom the age was provided) in a range of 21 to 49, and an average length of service of 1 year 5 months in a range of 1 month to 2 years 6 months. At the time of completing the questionnaires, the respondents had worked in the care profession for an average of 4 years 4 months in a range of 13 months to 9 years. In the year prior to completion of the SAF, three staff members had left, one to return to university, one for promotion to another unit and one transferred to the head office.

The Registered Persons stated in the SAF that no agency staff had been employed since the unit opened.

Information provided with the SAF indicated that staff meetings are held on a monthly basis, but the Manager said that he had found that more staff attend if they are less frequent and he now aims for every 6-8 weeks.

Recruitment

The home has a recruitment policy but it was not examined on this occasion but which OCS stated in the SAF had been reviewed since the last inspection. The Registered Persons stated in the SAF that all staff have an enhanced CRB check prior to commencing employment and that repeat checks are obtained every three years.

One staff file was examined, and contained all the required records, but one of the references had been received a few days after the staff member had commenced employment. This had been two years ago and the Manager said that no-one would now commence employment until all checks and references had been received.

The Registered Persons stated in the SAF that enhanced CRB checks are undertaken for all staff prior to their commencing employment, and this was confirmed on the staff file examined, and are repeated every three years. In response to a previous requirement the Manager said that a small safe had been purchased for the purposes of storing enhanced CRB disclosures, and that only he and the Human Resources Manager had keys to enable access for CSSIW inspections if required.

Appointments are subject to a six month probationary period.

Training and Development

Two of the respondents to the staff questionnaire had said that they had an individual plan of agreed training, one had said they did not.

The Registered Persons stated in the SAF that core training is provided as part of the organisation's induction package and includes sessions on Health and Safety; First Aid; Food Hygiene; Fire Safety; Protection of Vulnerable Adults (PoVA); Mental Health National Framework; Manual Handling, COSHH and four days training on Physical Intervention and this was evidenced with a copy of the induction timetable. All staff are required to undertake this training and they further state that all training is updated on a one- to three-yearly basis or as identified through performance management. If staff fail to attend required training it is re-scheduled at an agreed date and if they fail to turn up the reason is investigated. Where necessary, they are taken through the organisation's disciplinary process and possibly suspended until the training is complete.

The Registered Persons indicated in the SAF that all care staff commence their induction programme on the first day of their employment with a two week induction at the head office covering all basic topics and including a visit to the home during the first week to meet the service users and staff. Subsequent to the inspection visit the Manager provided a set of documents covering Module One of the new OCS induction pack. It stated in these documents that, where appropriate it had been cross referenced to the CCW Code of Practice as well as the Social Care Induction Framework, and that staff

would receive a copy of the complete CCW Code of Practice in their induction pack.

The SAF indicated that none of the staff had had training in infection control, and the Manager confirmed that this was still the case at the time of the inspection visit, but that the company had just made this training available and he planned to have all the staff trained within six weeks. All staff, including new staff, had done all of the core training apart from one member of staff who had to retake the food hygiene training at the end of the month.

There are separate training records for each member of staff and these were seen on the inspection visit and were detailed and well organised and included evidence of training undertaken.

Supervision and Support

Respondents to the staff questionnaire had received individual supervision from their managers at intervals of between one and two months which is in accordance with NMS 27.4 which recommends at least once every two months. The Registered Persons stated in the SAF that additionally support sessions are undertaken as necessary.

Supervision records are kept in individual staff files and these were examined for one member of staff. All the supervision records were signed by the employee and the staff member carrying out the supervision, but the frequency had not always been two monthly as required by NMS 27.4. The Manager said that there had been gaps in supervision during the previous year but that more staff had now been trained in supervision and they now aimed for each staff member to have a supervision session every two months. The Manager and Deputy Manager supervise the Senior Support Workers and the Seniors supervise the Support Workers. A chart was seen indicating that supervisions had been carried out on a two-monthly basis.

All respondents to the staff questionnaire had said that they had annual appraisals.

The Registered Persons stated in the SAF that on call is available 24 hours a day on a rota basis, and that there are two levels of the on-call system. The first (Bronze Level) is operated by the Managers and Deputy Managers of Conway House and another local OCS home, and the second level (Silver Level) is operated by Senior Management as contact for the Bronze on-call. All respondents to the staff questionnaire had stated that they knew what the on-call arrangements were should they need them.

There is a comprehensive ‘Disciplinary and Appeals’ procedure and, following a previous requirement, does now include that failure on the part of an employee to report an incident of abuse or suspected abuse of a service user is a ground on which disciplinary proceedings may be instituted, as required under Regulation 22(1)(b). There is also a comprehensive grievance procedure.

Requirements made since the last inspection report which have been met: Not applicable

Action required	When completed	Regulation number

Requirements which remain outstanding: Not applicable

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection: Not applicable

Action required	Timescale for completion	Regulation number

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.

CONDUCT AND MANAGEMENT OF THE HOME

Inspector's findings:

Day-to-Day Operations

The Manager has held NVQ Level 4 RMA since 2002 and the home and the service users appear to be benefiting from the Manager's full-time input. The Registered Persons stated in the SAF that there had been no changes in the management arrangements since the previous inspection. The Manager is competent and experienced to run the home and meet its stated purpose, aims and objectives. There is an identified Deputy Manager who could cover in the absence of the Registered Manager and who was present for most of the inspection visit.

The Registered Persons stated in the SAF that since the last inspection the Manager had undertaken training in Physical Intervention (SSTS), Food Hygiene, Health and Safety, Protection of Vulnerable Adults (PoVA), supervision, fire marshalling, medication, and COSHH.

Ethos

Service users benefit from the ethos, leadership and management approach of the home which creates an open, positive and inclusive atmosphere, and this was observed on the inspection visit.

The responses in the staff questionnaire to the question 'Do you feel valued by the management of the home?' had been: 'Always' –2; and 'Mostly' –1. In response to the question regarding having enough support to competently do the job, all had answered 'Always' (2) or 'Mostly' (1).

Respondents to the staff questionnaire had said that they are 'Always' (2) or 'Sometimes' (1) given opportunity to contribute their ideas and make suggestions.

Quality Assurance

The Registered Persons stated in the SAF that what they feel the service has done well since the last inspection is: maintain a clean and comfortable living environment; acted on CSSIW recommendations; developed the staff team and enhanced the skills of the service users. They also stated that there had been no constraints on the development of the service.

The Registered Persons further stated in the SAF that the quality of the service is reviewed via monthly staff and service user meetings, quarterly visits by the RI or Area Manager (a copy of the report of one of which was provided with the SAF), and, from 2008, six monthly by the Registered Manager. The copy of a provider visit report stated that the visits are designed to provide a monitoring tool to aid service development and ensure consistent quality provision, and are carried out on a three-monthly basis on behalf of the Registered Provider under Regulation 27.

Other methods used include audits, health and safety and environment weekly audits, questionnaires and consultations with service users, staff and other bodies including

placing authorities. There is also a legal requirement for consultation with service users' representatives.

Although the Registered Persons stated in the SAF that the annual report of the review of the quality of care was to be compiled in December 2007, this has not yet been received. In response to the requirement for this the Registered Persons had said that a service user questionnaire had been developed and implemented and that the results were being collated, and that a survey questionnaire for purchasers was being developed and would be sent out at the end of February 2008. They further stated that a full annual staff survey was being developed by the company to cover all employees and was to be circulated later that year. An example of the service user questionnaire had been attached with their response.

All of these elements contribute to the review of the quality of care, but there still needs to be an overall review of the results of the various elements (as detailed in the previous inspection report) and action to be taken as a result, and a report produced covering all elements of the legislation. This was discussed with the Manager and it was explained that a company report would be acceptable as long as it clearly discussed findings in relation to the individual settings. If not, the Manager would need to ensure compliance with the legislation with regard to Conway House.

The Registered Persons stated in the SAF that plans for the service over the next twelve months included continuing to identify suitable service users to maintain occupancy levels, reviewing all policies and procedures, reviewing the quality of care programme and audits, and updating and formalising the staff and service user questionnaires.

Policies and Procedures

The home has a comprehensive range of written policies and procedures, a list of which was provided with the SAF. The Registered Persons stated in the SAF that their policies and procedures are discussed with service users, individually and during service user meetings, and that they continue to be improved by the OCS Policy Management Working Group. Staff have access to policies and procedures which are kept in a file in the office. The policy working group is currently reviewing all the company's policies and procedures and sending revised ones to settings at the rate of about three per month. Old policies and procedures remain in place until they have been revised and the Manager has checked them.

Following a previous requirement, the staff 'Dismissal and Disciplinary Policy' had been amended to include that failure to report abuse or suspected abuse of a service user was a ground on which disciplinary procedures may be instituted, and had been forwarded to the policy and procedure group for ratification.

Record Keeping

Service user records are kept on shelves and staff records in locked filing cabinets in the office which is lockable. Service users' daily records are kept in the second office which is also lockable. The Manager said that computer records are password protected. Service users and staff can access their records via the Manager.

All required records were kept (except for service user marital status).

Following a previous requirement the Registered Persons had responded that all accident reports are now numbered. The accident forms now used have identified space for action taken.

Safe Working Practices

Two respondents to the staff questionnaire had said that they had the right equipment to competently do their job, one had responded 'No' and commented "credit on house mobile".

Staff induction training includes sessions on safe working practices as detailed above under Training and Development.

Certificates dated 30th May, 2008 for gas safety inspections by CORGI registered gas engineers for the heating boiler (they have no gas appliances), an Electrical Wiring Periodic Inspection Certificate dated 1st December, 2007 and valid for three years, and a certificate for their portable electrical appliances dated 26th May, 2008 were seen on the inspection visit.

The Registered Persons stated in the SAF that there are thermostatic blending valves on all hot water outlets and that the water temperatures are tested and recorded on a weekly basis, and that refrigerator and freezer temperatures are checked and recorded on a daily basis.

They further stated in the SAF that there are a fire risk assessment, fire safety policy, emergency plan, and log book, and also COSHH risk assessment sheets for cleaning chemicals.

Conduct of the Service

The Registered Persons stated in the SAF that the service continues to be financially viable and that the accounts are audited by an accountant at the head office on a monthly basis, and were last audited by external accountants in July 2007. No recommendations had been made as a result of this audit.

The employers' liability insurance certificate was displayed in the hall and expires on 29th April, 2009. The registration certificate was also displayed in the hall.

Areas identified in the SAF for further improvement were formal quality of care reviews and ensuring all staff work to company policies and procedures.

The Registered Persons stated in the SAF that plans for the next year were to: continue to identify suitable service users to maintain occupancy; review all policies and procedures; review quality of care programmes and audits; and update and formalise staff and service user questionnaires.

Requirements made since the last inspection report which have been met: Not applicable

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number
In order to comply with Regulation 25 as amended by The Care Standards Act 2000 and the Children Act 1989 (Regulatory Reform and Complaints) (Wales) Regulations 2006, the Registered Persons must review the quality of care at least annually, obtain the views of staff and any local authority which has arranged for the accommodation of a service user (in addition to those of service users and their representatives), and within 28 days prepare a report of the review and make it available on request as specified.	31/12/07	25 (1)

New requirements from this inspection: Not applicable

Action required	Timescale for completion	Regulation number

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.

CONCERNS, COMPLAINTS AND PROTECTION

Inspector's findings:

Complaints and Concerns

All respondents to the staff questionnaire had felt that service users' concerns/complaints are taken seriously and responded to properly.

The Registered Persons stated in the SAF that there had been no complaints since the last inspection.

Information provided with the SAF indicated that none of the staff had had complaints training which has been a legal requirement under Regulation 23.-(5) since 1st January, 2007. The Manager agreed that he could train the staff in the complaints procedure as part of the next staff meeting due the following week.

The Registered Persons stated in the SAF that the complaints procedure is available in English but that other formats, such as Welsh or tape, would be made available if there was an identified need for this. The complaints procedure had been amended as a result of a previous requirement and was mostly in accordance with current legislation except that:

* it stated 14 working days as the timescale for resolution of complaints but the legislation only allows 14 days.

* it does not include the arrangements for consideration of complaints made about the Registered Person.

A record is kept of all issues raised or complaints made by service users in a book which is kept in the office and was seen during the inspection visit and contained details of one complaint which had been dealt with by the company's complaints officer.

Protection

Following a previous requirement the 'Abuse of Vulnerable Adults' policy had been amended but was still not fully in accordance with the statutory guidance ('In Safe Hands') and local PoVA procedures, and the 'Employee Disclosure of Misconduct (Whistleblowing) Policy' still did not include that failure to report an incident of abuse or suspected abuse is a ground on which disciplinary proceedings may be instituted.

The Registered Persons stated in the SAF that there had been no adult protection referrals since the last inspection.

Requirements made since the last inspection report which have been met: Not applicable

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number
The Registered Persons must, within two months, produce a new complaints procedure in accordance with the new legislation as detailed above and send a copy to CSSIW.	20/08/07	23 (1)
In order to comply with Regulation 13.-(6), the Registered Persons must, within two months, amend the Adult Protection and Prevention of Abuse Policy and the Employee Disclosure of Misconduct (Whistleblowing) policy, as detailed to the RI, to ensure that they are in accordance with the locally agreed PoVA procedures, and send a copy to CSSIW.	20/08/07	13 (6)

New requirements from this inspection:

Action required	Timescale for completion	Regulation number
In order to comply with Regulation 23.-(5), the Registered Persons must ensure that staff are appropriately trained in the complaints procedure.	31/07/08	23 (5)

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.

ENVIRONMENT

Inspector's findings:

Premises

The home is a large, converted commercial premises situated in a residential area near to Cardiff city centre, but with many local facilities including shops, supermarkets, post office, banks, restaurants, cafes, and pubs. There were high standards of décor and cleanliness throughout the home.

The Statement of Purpose states that the home has eight bedrooms varying in size from $13m^2$ to $19m^2$ compared with the NMS of $12m^2$.

The Registered Persons stated in the SAF that the only changes to the premises since the last inspection had been redecoration.

Individual Rooms

There are eight single bedsitting rooms on three floors, three of which have en suite facilities, the rest of which have wash basins. The rooms are lockable and all of the current service users have keys to their rooms. The Manager said that they were having a different lock fitted to meet the needs of one service user, and that there is a lockable drawer or cupboard in each of the service user's rooms.

Shared Space

There is a communal lounge and a through lounge/dining area next to the kitchen, all of which had high standards of décor and cleanliness. The separate lounge has a computer and internet access and a service user was observed using this. The Manager said that there is internet access in all bedsitting rooms for those service users who have their own computers and that two service users currently use this.

The home has eight toilets for eight service users, three of which are en-suite, which is above the National Minimum Standard of their being shared by no more than two people. There are five bath/shower rooms, three of which are en-suite, which is in accordance with the National Minimum Standard of their being shared by no more than three people.

All respondents to the staff questionnaire had thought that the safety and security of service user and staff personal items was sufficient.

There is a small but well maintained patio area at the rear of the property with seating and pots and hanging baskets with flowering plants which are maintained by a service user.

Adaptations and Equipment

None of the current service users needs special equipment and no adaptations have been needed to the home.

None of the respondents to the staff questionnaire had thought that improvements were needed to the standard of facilities in the home.

Hygiene and Control of Infection

All respondents to the staff questionnaire had thought that the standard of cleanliness in the home was ‘Very good’ (2) or ‘Good’ (1), and this was observed on the inspection visit.

All respondents to the staff questionnaire had thought that the way in which the service users’ laundry is managed was ‘Very good’ (1) or ‘Good’ (2) and none had suggested improvements to the laundry arrangements.

The Registered Persons indicated in the SAF that none of the staff had had training in infection control and this was still the case at the time of the inspection visit, but training had been put in place and was due to commence and the Manager said that all staff would probably have received this within six weeks.

The Registered Persons stated in the SAF that they have a contract for the safe disposal of non-infected waste and a copy of the ‘Duty of Care’ notice from an approved contractor.

Requirements made since the last inspection report which have been met: Not Applicable

Action required	When completed	Regulation number

Requirements which remain outstanding: Not applicable

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection: Not applicable

Action required	Timescale for completion	Regulation number

Good Practice Recommendations:
There were no recommendations arising from this inspection episode.