

Langley House Trust

The Shrubbbery

Inspection report

35 Frindsbury Road
Rochester
Kent
ME2 4TD






Date of inspection visit:
01 March 2016
02 March 2016

Date of publication:
08 July 2016

Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

The Shrubbery is a home run by a Christian charity working with people who are at risk of offending, or have offended. The home's aim is to provide assistance and support for people so that they can lead crime-free lives. The home provides support on a 24 hour basis and is planned to assist people to increase their daily living skills so they can move on to independent accommodation. They offer support for up to 15 people.

The accommodation was set in a detached property over three floors as well as a separate annex and an independent flat. At the time of our visit, there were five people who lived in the home.

The home had 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.

The home was safe. Risk assessments were in place for every person living in the home and covered a wide range of potential risks. The assessments were very thorough, identifying risk and how to mitigate it. They were constantly being reviewed and updated. Some people were not allowed to leave the building without a daily risk assessment being completed.

Environmental risk assessments were in place and safety certificates for gas and electricity were up to date. There were fire evacuation procedures in place although people did not have personal evacuation plans. Staff were able to describe how they would support people to evacuate in an the event of an emergency.

The provider had a safeguarding policy and procedure in place and staff had received training in safeguarding vulnerable adults. This policy made reference to the local authority's safeguarding protocols but there was not a copy of this protocol in the home. Despite this staff were able to confidently tell us what their responsibilities were in relation to keeping people safe. We have made a recommendation about this.

Accidents and incidents had been responded to appropriately and the registered manager had put in place procedures following one specific incident that ensured protection for people living in the home.

Staff rotas showed that there were enough staff on duty to meet people's needs and in line with the providers staffing policy.

The provider had a recruitment policy in place and records showed that recruitment practices were safe. References had been gathered, Disclosure and Barring checks (DBS) had been completed and gaps in employment history had been explored before staff commenced working.

The provider had a medicines policy in place which the staff were following. Medicines were stored correctly and medication administration records (MARs) were completed correctly. Medicine audits were carried out

on a daily and weekly basis.

The home were not providing care in line with the Mental Capacity Act 2005 (MCA) or taking into account Deprivation of Liberty Safeguards (DoLS). People that had no legal restrictions in place were not able to leave the home unless staff allowed them to. The registered provider and manager had not considered that these people would need a DoLS in place. Staff and the registered manager did not have a clear understanding of how the Mental Capacity Act and the need to consider people's consent to care and treatment fed into the support they provided.

The provider had a training schedule in place for the whole of 2016. The registered manager did not have a training matrix in place and had no overall view of what training might be out of date. We were provided with additional information after the inspection but it was still not clear whether all training was up to date. We have made a recommendation about this.

Staff completed residential inductions to the trust, received regular supervision and annual appraisals. They were supported in their roles.

People were supported to have access to routine health appointments such as doctors and physiotherapy appointments.

People were supported and encouraged to maintain a healthy and nutritious diet. The kitchen was well stocked and people were given a choice of meals. There was access to healthy snacks with a large fruit bowl in the dining room, and access to drinks throughout the day.

We saw staff engaging with people in a kind and compassionate way. People told us that the staff were kind and helpful to them.

People were supported to increase their independent living skills as much as possible. For example, staff organised for people to attend financial budgeting classes. They were also supported to resolve debt related issues.

Records showed that people had been actively involved in the drawing up and reviewing of their care plans.

Staff knew about the importance of confidentiality and to ensure that private conversations were held where other people could not hear. Care records and other management records were kept in locked office that only people authorised could have access to.

People's privacy and dignity was protected and people's religious and cultural views were taken into account. People also had access to independent advocates if they needed this support.

Pre admission assessments were very thorough and health care professionals were particularly impressed with this process. These clearly fed in to care plans that were drawn up in conjunction with people, taking into account their likes and dislikes and assessed needs. These documents and risk assessments were regularly reviewed.

People were supported to take part in meaningful activities if they wanted to. People were able to go out on organised trips and the home arranged trips that people had specifically requested.

People had regular access to the surrounding community and were involved in helping at local charities

such as the food bank.

The provider had a complaints policy and procedure in place which gave information on how people could make a complaint if they needed. People told us they knew how to complain and staff supported them to do so if necessary.

The home had transition plans in place to support people to move on when it was felt they were ready to do so.

The registered manager was aware of their responsibilities however there was a lack of clarity between the home and head office about reporting responsibilities to the Care Quality Commission. Some incidents had not been notified to the CQC.

There were systems and processes in place to ensure the monitoring of quality in the home. Improvements had been made to medicines management as a result of monitoring.

Staff spoke of an open culture and everyone said they felt supported in their role. The registered manager also felt supported by the provider.

They kept up to date with best practice by attending local forums and accessing training and support from local providers. Staff had received additional training to support one person with a specific diagnosis.

The visions and values of the trust were based on Christian principles, about seeing the person as a whole and giving people a second chance. We observed staff echoing these principles in the care and attention they gave people.

Communication between staff and the registered manager was good, with shift plans being completed as well as verbal handovers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

There were thorough risk assessments in place that were regularly reviewed, in some case on a daily basis.

There was a safeguarding policy and procedure in place. This made reference to the local authorities safeguarding protocols but there was not a copy of this in the home. Staff and the registered manager were aware of their responsibilities to keep people safe.

The provider had a recruitment policy in place and recruitment practices were safe.

Accidents and incidents had been responded to appropriately.

Is the service effective?

Requires Improvement ●

The home was not always effective.

People were restricted from leaving the building but did not have Deprivation of Liberty Safeguards (DoLS) in place. There was not a clear understanding around how the Mental Capacity Act 2005 should feed in to support being given.

The registered manager had no overall view of the training needs of the staff.

Staff had completed residential inductions before starting work and they received regular supervisions and appraisals.

People were encouraged to maintain a healthy diet and access to snacks and drinks throughout the day.

Is the service caring?

Good ●

The home was caring.

Staff were seen to interact with people in a kind and compassionate way.

People were supported to be as independent as possible.

People's religious and cultural beliefs were taken into account.

Staff knew about the importance of keeping things confidential and records could only be accessed by those authorised to do so.

Is the service responsive?

Good ●

The home was responsive.

Pre admission assessments were very thorough and fed into people's care plans.

People had access and were encouraged to participate in meaningful activities.

People regularly accessed the local community and were protected from the risk of social isolation.

There were transition plans in place for people when they were ready to move on.

Is the service well-led?

Requires Improvement ●

The home was not consistently well led.

Incidents the registered manager and provider were responsible for reporting to the CQC had not always been reported.

Auditing systems were in place and very thorough.

The staff and the registered manager felt supported.

There was a clear people focused culture within the organisation and the home.

The visions and values of the home, in line with Christian principles were very clear through the staff and their actions.

The Shrubbbery

Detailed findings

Background to this inspection

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

This inspection took place on the 1 and 2 March 2016 and was unannounced. The inspection team consisted of one inspector. Before the inspection, we reviewed previous inspection reports and notifications before the inspection. A notification is information about important events which the home is required to send us by law. We looked at safeguarding information we had received. There was no provider information return available.

We also spoke with five staff including two support workers, the cook, the deputy manager and the registered manager. We spoke to three people who lived in the home. We contacted health and social care professionals to obtain feedback about their experience of the home.

We observed care and support being provided. We looked at records held by the provider and care records held in the home. These included two people's care records, risk assessments, staff rotas, four staff recruitment records, meeting minutes, policies and procedures, satisfaction surveys and other management records.

At our last inspection on 25 October 2013, we had no concerns and there were no breaches of regulations.

Is the service safe?

Our findings

People told us that they felt safe in the home. "If I'm worried I talk to any member of staff."

Appropriate risk assessments were in place for each person living in the home. They covered a broad area of potential risks. People might be at risk of offending or reoffending and risk assessments were in place to mitigate this. Other risk assessments included whether people were at risk to the general public, children and females. Some people may be at risk of self-harm or harm from other people in the home and risk assessments were in place for this. They were updated on a regular basis or when there was a change in need. Records showed that one person's risk assessments had been updated following an incident with another person living in the home. Risk assessments were also carried out every time people wanted to leave the building. People were not able to leave the building until these risk assessments had been signed off by those authorised to do so. If this member of staff was not in the building the authorisation would be done over the phone. The provider was aware of the potential high risk that people living in the home posed and that they looked to protect people, staff and the general public.

There were environmental risk assessments in place for the home. Gas and electrical equipment had been tested on a regular basis and certificates were up to date. There were health and safety risk assessments in place for things such as back injury, intruders, infection control and first aid. There was also a legionella risk assessment in place and water was tested on a monthly basis. These had been reviewed on a regularly and records showed that staff had signed and dated these reviews. The provider was protecting people and staff from harm and potential risks in the surrounding environment.

The provider had put in place fire evacuation procedures. Fire extinguishers had been serviced on a regular basis and fire alarms were tested weekly. Fire risk assessments were in place. Most people were independent and able to move around the home without assistance. There were no personal evacuation plans in place for people however there were crib cards available for staff to use to prompt them on how to support people to leave the building in the event of an emergency. Staff were able to tell us how to support people and were aware that one person in particular would need extra support with orientation to leave the building. Staff knew how to support people in the event of an emergency. The provider also had a business continuity risk assessment and plan in place in the event of a loss of use of facilities or staffing. This included staff contact details, people's individual details as well as key information such as what medicines they were taking.

The provider had a safeguarding policy and procedure in place. This made reference to the local authority's safeguarding procedures and protocols however, there was not a copy of this in the home. Staff had received training in safeguarding vulnerable adults and were able to recognise the potential types of abuse and what to do if they had any concerns. The provider had a whistleblowing policy in place. Staff were aware of the policy and what to do if they needed to use it.

We recommend the provider ensures there is a copy of the local authority's safeguarding protocols and procedures in the home.

We spoke to the registered manager about how they determine the correct staffing levels to meet people's needs. They told us that it was worked out on the basis of two and half project workers for 15 people. Staffing rotas showed that there were always two project workers on duty. The registered manager and deputy manager also worked in the home from Monday to Friday and were supernumerary. There were enough staff on duty to meet people's assessed needs.

Accidents and incidents were responded to and recorded in line with the provider's policy. For example there had been an incident between two people living in the service. A staff meeting was held. The incident was discussed along with what lessons could be learnt and what to put in place to prevent further incidents happening again. It had been decided that staff needed to be on the floor at all times whilst one person was in communal areas to prevent further incidents. During the inspection we observed staff keeping to this guidance. The provider was responding appropriately to accidents and incidents.

The provider had a recruitment policy in place and recruitment practices were safe. Interviews were carried out and references had been gathered. Staff had been vetted before they started working at the home through the Disclosure and Barring Service (DBS) and we saw evidence of this on staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Some staff records we looked at were for staff that had been typed over from another service and there were gaps in employment history. All current files we looked at explored gaps in employment history as a matter of course. People were protected from receiving care from unsuitable staff.

The provider had a medicines policy in place which the home was following. Medicines were stored and disposed of safely. All medicines were stored in a locked cabinet in a secure office that only staff had access to. There was a system in place where one member of staff per shift held the key to the medicines cabinet in order to give more accountability. Medicines were delivered by a local pharmacy that also carried out a medicines audit. This audit suggested the use of a dosset box system which the home had gone on to implement. Medication Administration Records (MAR) were used and medicines were recorded correctly. One person was administering their own medicines. They would pick up their own prescription and hand this to staff to store correctly. Staff would then give the person a weeks' worth of medicines at one time. This would be recorded on the MAR sheets. There was a risk assessment in place which had been reviewed and updated and signed by the person and staff. Staff were carrying out medicines audits on a daily and weekly basis. This meant that people were protected from the risks associated with the management of medicines.

Is the service effective?

Our findings

People told us that they liked the way staff looked after them. One person told us "they used to do everything for me and I didn't like that. I will ask if I can't do it and they respect that."

Care and support was not delivered in line with the Mental Capacity Act 2005 (MCA) or taking into account Deprivation of Liberty Safeguards (DoLS). One person had a restriction under the Mental Health Act and had to be escorted when leaving the premises. None of the other people living in the home were subject to a Deprivation of Liberty Safeguard (DoLS). The building was locked and people were unable to leave the premises without staff allowing them to do so. We spoke to the registered manager about this and they were unaware that people would need a DoLS and had not applied for any. Training records showed that only the deputy manager had received training in DoLS. All staff had received training in the Mental Capacity Act 2005. We spoke to staff who told us that every person in the home had capacity apart from one person. Staff were unclear how to put the MCA into practice when giving care. Care plans did not evidence that people's capacity had been taken into account. The registered manager and staff did not have a good understanding of DoLS or the Mental Capacity Act. This meant that there was no consideration for people's consent to care and other daily routines.

This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a training policy in place and a training schedule across the group for 2016. Records showed that some staff had received training in addition to training the provider considered mandatory. This included working with offenders who had committed specific offences. The registered manager had access to some training records but it was unclear from these records which staff's training was up to date. They advised us that this was collated from head office on a new IT system which they had yet to have access to. There was no training matrix in place and the registered manager had to collate training records in order to establish if training was up to date. We were sent this information after the inspection. It was still not clear from this if people's training was up to date or not. The provider's training schedule made reference to annual refresher training for example safeguarding and the Mental Capacity Act. These were out of date on the information sent to us. Due to the systems in place the registered manager did not have an overall view of training for their staff. People might be at risk of being cared for by staff whose training was out of date and not be in line with best practice.

Staff told us that they had completed a residential induction course. "It was really good; we went away for three days." Staff records showed that supervisions had been carried out on a regular basis. Annual appraisals were carried out where staff's job performance was discussed along with their future aspirations and training needs. Staff were supported to carry out their roles.

People were supported to access routine medical treatment from health care professionals. One person told said "I have regular health check-ups. Blood tests, physio on Thursday's and Friday I see my consultant." There were records on people's care plans of appointments with health care professionals including

doctors' appointments and sessions with psychologists. Referrals to health care professionals were made in a timely manner such as to the memory clinic and psychologists. One health care professional told us that they had been impressed with the service and that they had sought mental health support appropriately for their client.

People were encouraged to maintain a healthy and nutritious diet. Some people didn't eat in the home but chose to eat outside, however, the key worker sessions encouraged people to make healthy choices. We spoke to the cook who told us that menus were put together after residents meetings. People had to make their choices a week in advance. If people changed their minds about what they wanted to eat then they could provide an alternative. We looked in the kitchen and food stores where there was plenty of fresh fruit and vegetables and freezers were well stocked. Food was delivered by local supermarkets as well as donations from the local food share scheme that makes donations of food to local charities. Food in jars that had been opened in the fridges did not have labels with dates of when opened on them. The cook told us that people and staff would come in to the kitchen and opened jars and not labelled them. This had been raised in their supervision. On the day of inspection the home was inspected by the local authority food hygiene department who gave them a rating of five.

Is the service caring?

Our findings

People were positive about the care they received from staff. "Most of the staff try to bend over backwards to help you. They are always polite." Health care professionals told us 'I have found staff at "The Shrubby" an excellent support to the adult I have placed there.'

We observed staff engaging with people in a kind and meaningful way and that they knew each other well. We heard them talking about what they were going to get up to that day. We observed people and staff enjoying lunch together. There was a pleasant atmosphere in the home. Staff explained to people who we were and why were in the home.

A key outcome for people living in the home was to be as independent as possible. One person told us that due to their disability "at first they did everything for me but I like to do stuff myself. I spoke to the staff and now they respect that. I ask if I want them to do anything for me." Staff told us "we support choice and independence and use guided encouragement." "We try to build a routine for people." People were supported to cook and clean. People were supported to budget their finances. Some people were struggling with their budgeting and were in rent arrears. Staff supported them by arranging budgeting workshops for them to attend as well as offering support with arranging agreements concerning rent arrears. People regularly accessed the surrounding community by themselves and used public transport. People were supported to be as independent as possible.

People were involved in drawing up of their own care plans. Records showed that people had signed all areas of their care plans and that they had been reviewed on a regular basis with the support of people's keyworkers.

Staff had a good understanding of the importance of confidentiality. They knew to have confidential conversations in the office or quiet room. When we spoke with people living in the home staff ensured that we had a private room that we could talk in. Care records and other confidential records were kept in the staff office where only people authorised to do so could access. Staff records were kept in a locked filing cabinet in the registered manager's office which was locked when empty.

People's privacy and dignity was protected. People told us that "staff always knock on the door and ask, are you decent, can we come in?" We observed staff knocking on doors before entering and staff told us that they always did this.

The provider's service was a Christian based charity. Staff we spoke to told us "no one here is particularly religious, some are agnostic. We respect people's beliefs. Yes we are a Christian based project but we don't impose this on people. We remind people that it's here and we have prayer meetings, but if they don't want to come we respect this view." Some people's daily notes showed that they attended local churches and the cathedral. People's religious views and culture was respected.

We did not have access to people's private bedrooms but the communal living areas were personalised. One

person had expressed an interest in carrying out decorating in the home and had been supported to do this in the communal lounge.

Some people had restrictions on who they could and could not see and it might not have been appropriate to maintain relationships with family members. The diary for the home made notes of significant events in people's lives. For example, of birthdays or the death of relatives, in order that staff were aware that people might need additional support on those days.

People had access to advocates if they needed. There was information available to people about advocates in the communal areas. Records showed that one person had accessed and been supported by an advocate when trying to resolve an issue with the probation service.

Is the service responsive?

Our findings

People told us that they thought the service was responsive. One person told us "I didn't like it in the main house so I asked to go to the cottage (the annex), which they arranged for me." Health care professionals said "I was particularly impressed with the assessment process prior to this person going there which really set the ground work for what has followed."

Pre admissions assessments were very thorough. They went into great detail with and about people. Initially the home used a survey style assessment encompassing areas such as what support people might need, empowerment, the constructive use of time, boundaries and expectation and positive identity. This fed into a service user needs assessment. All documents had been put together and signed and agreed with the person. The needs assessment had a full history about the person and their offences and the circumstances surrounding them. All this information was pulled together to produce a care plan. Care plans were produced in a format suitable for the person. One person had problems with literacy had a pictorial care plan. People had access to their own care plans. The plans were reviewed on a regular basis and risk assessments were updated when needed, sometimes on a daily basis. Health care professionals reported that the home were very good at keeping in touch and said "their keyworker always keeps in touch with any developments."

People with literacy problems were supported with a reading programme called Toe to Toe. By enabling people to be able to read the home were promoting people's ability to live independently.

People were able to carry out meaningful activities if they wanted to. Keyworkers worked with people to produce a planner personal to them. There were scheduled trips that people could participate in. Staff and people told us that spontaneous trips were not as easy at the weekends due to the use of agency staff that were unable to drive. One person told us that their keyworker always offered activities "I don't do them, but they are there if I want to do them." Copies of resident's meetings showed there had been a request for the pool table to be refurbished. The following month's minutes confirmed that this has been completed and we saw people playing pool. There had been a request to go to the local Christmas market as well as Dicken's Christmas world. In December we saw that people had been to both events. People were encouraged to participate in meaningful activities.

The home actively encouraged people to engage with outside agencies. People told us that they had done voluntary work at local charity shops. People also worked at the local food bank and at Fort Amherst helping to carry out ground works. This meant they would be less risk of social isolation and be better able to integrate into the community.

Some people had problems with different types of addictions. People were actively encouraged to seek help for these problems and people told us that they regularly attended local support group meetings. Some people found these meetings helpful to deal with their addictions, whilst for others the meetings did not work. These concerns were discussed in keyworker meetings. One person was supported to attend smoking

cessation sessions and had successfully stopped smoking. This meant that people were actively encouraged to make improvements to their health.

The provider had a complaints policy and separate complaints procedure in place. This gave details of how people could make a complaint and who to contact in the event that they were not happy with the provider's response. We spoke to staff who told us that they would support people to be able to make a complaint if they needed to. People told us that they would speak to their keyworker if they had a complaint and were not concerned about making a complaint if they needed to. The registered manager told us that they sat in the quiet room at the same time every morning so that people could come and talk to them about any concerns they had. Recently people had complained that they didn't like one of the chicken dishes on the menu and this had been removed.

The provider carried out resident satisfaction survey's the results of which were positive. People told us that they had been asked to complete one recently and that their key worker had supported them with this. People's opinions were regularly sought. People were also involved in the running of the charity. The provider held a National Consultative Group which met every six months. One person from each project would attend this. The purpose of the group was to look at possible changes to policies and procedures, look at resident's satisfaction surveys and see if improvements could be made. One person was particularly enthusiastic and had attended this group on a regular basis.

The nature of the service was to promote independence and to allow people to eventually move on and be able to live independently. The registered manager told us that no one had moved on since the project had opened but that people had transition plans in place. These included supporting people to get onto local housing registers, and helping people with practical support such as sourcing furniture and white goods from local charities. The provider had appropriate procedures and plans in place to support people to move on when they were ready to do so.

Is the service well-led?

Our findings

People told us that they thought the home was well-led. "The registered manager is very approachable." One health care professional told us when we asked if they thought the home was well led "that's a big yes."

We spoke to the registered manager about their role and responsibilities. They told us that it was their responsibility to ensure that the home was run professionally, that staff were trained and supported. People had person centred care plans in place that were audited and reviewed regularly. That people's views were listened to and that they were helped and guided through the trust's processes. They were aware of their reporting responsibility to the CQC however records showed that some incidents which should have been reported had not been. They told us that there was a quality compliance manager that made notifications to the CQC and that they had assumed that they had made the appropriate notifications. We saw that in one person's care plan safeguarding alerts had been raised with the local authority on the 17 September 2015, 26 November 2015 and 25 December 2015. However, following the inspection we received information from the registered manager that two of the three incidences had not been reported to the local authority safeguarding team. We could find no record of being notified about these alerts. Records also showed a reportable incident had occurred on the 3 May 2015 which we were also unaware of. There was a lack of clarity between the home and head office about reporting responsibilities to the local authority safeguarding team and CQC.

The provider had failed to notify CQC of reportable incidents and safeguarding this was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The registered manager had systems and processes in place to audit and monitor the quality of the service. This included monitoring the risks relating to people and staffs health and safety. There were regular quality assurance audits carried out by the provider. Audits had a red/amber/green monitoring system in place. Red and amber audit's would trigger action plans to be put in place and completed by the registered manager. Records showed that audits had been green for the previous 12 months. If medicines errors were recorded audits automatically defaulted to red. The registered manager told us that 18 months ago there were a lot of medicines errors happening. As a result a new medicines system was put in place at the home by a local pharmacy. There had also been a change in the medicines policy resulting in daily medicines audits and only one member of staff per shift having keys to the medicines cupboard in order to provide more accountability. This meant that registered manager was ensuring they were appropriately monitoring the quality of the service and making improvements where necessary.

There were daily records of how people living in the home were cared for and what treatment they had received on a day to day basis. For example, how people had been cared for, what they had been up to and what they had eaten. Other documentation relating to the running of the home was kept up to date. This meant that the registered manager was keeping auditable records to ensure people were supported appropriately and to ensure the smooth running of the home.

Staff told us that they felt much supported by the registered manager. "There is an open culture and we've got a great manager." "We have supervision every month and we can talk about pretty much anything." The deputy manager had been with the project since 2002 and said they felt very supported. Other staff told us that the registered manager was approachable. Staff meetings were held on a regular basis and showed that the registered manager and provider responded to staff suggestions. Following on from an incident that one member of staff had been involved in; they had suggested that all staff carry first aid pouches. This suggestion had now been implemented across the whole trust and every member of staff carried a clip on first aid pouch. Staff and their family members were also able to access counselling support via the trust if they needed it. The staff felt supported to carry out their roles and responsibilities.

The registered manager told us they had supervision ten times a year and that they regularly attended managers meetings. They spoke of a very open organisation. "I can phone the chief executive if I want to. It wouldn't seem odd. There's openness." They also told us that the provider held an open surgery which they could attend if they needed additional support. We asked them how they kept up to date with best practice. They told us that they regularly accessed the CQC and other websites. They attended the local provider forums and said that they found the peer support from these events particularly useful. One person living in the home had a diagnosis of dementia. The home had not supported someone with this diagnosis before so they sought the help of the local Alzheimer's society for training for staff. This had resulted in different approach to the support being given to this person as well as considering issues such as orientation around the home. This meant that people were being supported taking into consideration best practice.

The registered manager told us that the visions and values of the trust were based on Christian principles. Those of honesty and integrity, giving people a second chance and looking at the person as a whole. Support was to be provided in a person centred way and based upon respect for each other. The way that staff supported and cared for people living in the home echoed these values.

Communication in the home between the staff and registered manager was good. Staff held a 30 minute verbal hand over at the beginning of the shift. Shift planners were drawn up delegating jobs to be done throughout the day. Important information and messages were written in a day book to keep staff informed. Staff had access to the trust's policies and procedures on a shared computer drive and the registered manager would go through policies at staff meetings that were new, or if staff didn't fully understand.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Accommodation for persons who require treatment for substance misuse	How the regulation was not being met:
Personal care	The provider had not notified CQC about important events such as, abuse and serious injuries.
	Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Accommodation for persons who require treatment for substance misuse	People were restricted from leaving the building but did not have Deprivation of Liberty Safeguards (DoLS) in place.
Personal care	