Methodist Homes

Adlington House

Inspection report

Nelstrop Road
Heaton Chapel
Stockport
Cheshire
SK4 5LT

Tel: 01619750411

Date of inspection visit:
07 April 2016
08 April 2016

Date of publication:
23 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7 and 8 April 2016 and was announced. The provider was given 48 hours notice. This is in line with our current guidance for inspecting domiciliary care services. This was the first inspection of the service since it was newly registered in July 2013.

Adlington House is registered to provide personal care to people who may require some help to maintain their independence. The purpose built three storey building, set in its own grounds, offers 52 self-contained retirement apartments. At the time of our inspection two apartments were shared by married couples and the rest were single occupancy.

The service provides care and support over a twenty four hour period. Staff can be called upon at any time to offer assistance to anyone living at Adlington House. People were able to purchase care packages to support them with their personal care. The service currently provided personal care support to seventeen people. All people who lived at Adlington House have access to an on-call system should they require assistance during the day or night. This service extended to those people living on site who had not purchased a care package with the service. If people's needs changed they could call on staff who knew them and purchase additional care as needed. This meant that they could access support very quickly, and tailor that support to meet their needs.

In addition care staff would check on the welfare of all people living at Adlington House on a daily basis. The service also provides companionship, domestic support, a chaplain, handyman services and escorts for people, for example when attending hospital appointments.

Access to the building was secure, with key code entry and a buzzer with a screen linking visitors directly to the apartment they wished to visit. The main office was situated on the ground floor by the reception area, and there were also a hairdressing salon, a well-equipped spa room where people could be bathed by staff; activities room, and quiet lounges for people who use the service to meet or spend some peaceful time alone. An outside catering company ran a restaurant situated on the ground floor which was popular and well used by the people who used the service. There was also a 'guest room' where visitors could stay overnight or for longer periods if necessary.

The service 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.

People told us they felt safe and secure and that support was provided by caring staff whom they trusted. There were good and efficient monitoring systems in place to check the welfare of all the people who lived at Adlington House, and we were told by one person that staff will "notice if anything is out of the ordinary".

We saw that there were enough well trained and competent staff to provide the level of support people required on a day-to-day basis. People we spoke with were complimentary about the staff. One person who used the service told us "The staff are all excellent. They know us, and they know what they're doing. The perfect combination!" We saw records that showed that the staff were regularly supervised and had an annual appraisal, and were encouraged to seek learning opportunities with access to ongoing training.

There was a consistent staff team with low staff turnover. This meant that care was delivered to people who required support by knowledgeable care staff who knew them well, and knew how they liked their care to be delivered.

Staff demonstrated a good understanding of how to safeguard adults at risk of harm, and the service had a safeguarding policy which was up to date, in line with recent legislation and complemented the local authority safeguarding procedures.

Adlington House had robust and effective systems to investigate incidents, complaints, staff conduct and safeguarding concerns, and used the information as an opportunity for learning.

Appropriate risk assessments were in place to reduce the risk of harm, and records were kept up to date, regularly reviewed and stored securely.

There was enough information in people's care records to guide staff on the care and support needs required. People and their relatives were involved and consulted about the development of their care records. This helped to make sure that the wishes of people who used the service were considered and planned. The care records showed that risks to people's health and well-being had been identified and clear instruction provided to help minimise risk.

Communal areas were well lit, clean and warm, and we saw that infection control procedures were in place to prevent the spread of infection. The building was well maintained with copies of maintenance records and servicing, for example, servicing of the lift, was carried out and recorded, with any necessary action taken to remedy faults.

The service was working to the principles of the Mental Capacity Act, 2005 and care staff supported people to make their own choices about their care and daily activities. People told us they were supported to make their own decisions, and we saw evidence that people's wishes were taken into consideration in planning their care. Their care records made clear what people required support with and what they could do independently.

We saw that staff understood the importance of a good diet and ensured people had enough to eat and drink, People could make their own meals or choose to eat their main meals in the restaurant, where catering staff were aware of their specific needs, and would check if people were missing at meal times. People told us they enjoyed the food provided, and lunchtime particularly was seen as an enjoyable social occasion.

Care was reviewed on a regular basis and individuals were involved in reviewing how and when their care was delivered. When needs changed the service would quickly respond and could arrange packages of care which could change from day to day.

The organisation recognises the risks of social isolation and has set up support mechanisms to combat this risk, and a variety of interest groups was available both within and outside the service. These included a

theatre club, travel club, film night and Chinese art class.

People were aware of how to complain. A copy of the complaints policy was prominently displayed near the building entrance. We saw that complaints were thoroughly investigated and the organisation kept a log of complaints which was reviewed and monitored for any trends.

People believed the home was well led. Staff told us the registered manager was supportive, encouraging and nurturing and people who used the service told us that the manager "makes the place work", and has "created a real family atmosphere which is a pleasure to belong to".

Quality of care was seen as integral to service delivery, and the service consistently strived to provide a high quality of care.

We saw that systems were in place to monitor the quality of the service provided, including opportunities for people who used the service to comment and assist with driving forward improvements.

The staff at Adlington House were vigilant to individual's needs and treated people in a caring and compassionate manner, taking time to get to know people's personal tastes and preferences. When we spoke to people who used the service they talked of genuine care being delivered in a person centred way. They told us that the staff were friendly and available. One person told us that the care staff were "keen to get everything just so. They have a mentality of making everything perfect".

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.
People told us that they felt safe and there were enough staff to meet their needs.

The service had an up to date safeguarding policy and staff understood their responsibilities to report any suspicion of abuse.

Risks to people's health and well-being had been identified and assessments identified control measures to minimise or prevent harm.

Adlington House had a good system in place for the safe recruitment of staff.

There were effective systems in place for managing medicines and the control of infection.

Is the service effective?

Good

The service was effective.

People were complimentary about the staff, telling us that they were knowledgeable and knew them well. We saw that staff received training to maintain and develop their skills to meet people's needs.

People's health was monitored and referrals to other health and care professionals were made to ensure care and treatment met people's individual needs.

Staff worked within the principles of the Mental Capacity Act (2005) and supported people to make their own decisions.

Is the service caring?

Good

The service was caring.

People told us that care was delivered by people who knew them well, and that they got on well with them.

People told us that they were treated in a caring and compassionate manner. Staff agreed that this was important and spoke affectionately about the people they supported.

People's privacy and dignity was respected.

Care records indicated people's interests, likes and dislikes, and they were encouraged to maintain and develop new interests.

Is the service responsive?

Good

The service was responsive.

People were encouraged to remain independent as long as possible and supported to make choices. Their wishes were respected.

Care and support was planned with people and they were involved in reviewing their care on a regular basis.

Care delivery was flexible, and staff could respond quickly and appropriately to any change in need. People were able to access services in a way and at a time that suits them.

People knew how to make a complaint and there was guidance to support people to do so.

There was a range of activities available, and friendship groups were encouraged.

Is the service well-led?

Good

The service was well led.

The service had a registered manager. Care staff we spoke to told us they felt well supported, and aware of their roles and responsibilities.

There were effective systems in place to monitor the quality of the service.

There were regular meeting for staff and for people who use the service to raise issues, provide feedback, and share information about the service.

Staff told us, that they were involved in discussions about issues in service provision and we saw that they were encouraged to raise issues and take responsibility for their actions.

Adlington House

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 8 April 2016. It was an announced inspection. The inspection team consisted of one adult social care inspector.

Prior to the inspection we reviewed information we held about the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.
We also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We also contacted the commissioners (who fund the care for some people) and the local safeguarding team. No concerns were reported about the care and support people received.

During the visit we spoke with four people who use the service, three visitors, the registered manager, the Senior Team Leader, two members of care staff, and a member of the restaurant staff.

We observed care and support in communal areas, and looked at the care records for four people who used the service; medication administration records, staff training records and two supervision files. In addition, we looked at a range of records relating to the running of the service, including quality assurance reviews and audits carried out by the registered manger and provider. We also reviewed a range of policies and procedures.

We looked at all the communal areas, and were invited to look in one person's apartment.

Good

Is the service safe?

Our findings

People who lived in Adlington House felt safe. One person told us "I have peace of mind, it's a safe place and the staff treat us kindly". Another person said, "They keep an eye on us and watch our comings and goings. They notice if anything is out of the ordinary". Not everybody who lived at Adlington House received personal care but the staff took responsibility for checking on the well-being of all people who lived at Adlington House. One person told us "I set off my pendant by mistake one time, and [a carer] were there in seconds. Nothing is too much trouble. It's a wonderful place, and the staff are wonderful". A daily 'register' was kept in the reception, and as people passed, they would be ticked off by the staff. If a person had not been seen by late afternoon staff would make enquiries as to their wellbeing. We were informed of a recent example where a person had not followed their daily routine, and so an early welfare check was made, and the person was found to be poorly. The person's doctor was called and this early intervention minimised the risk of a serious deterioration in health.

The building was secure. Entry through the main entrance was controlled by an intercom with a screen to each individual apartment allowing people who lived at Adlington House to allow entry to their visitors. The main office overlooked the reception, so staff could challenge anyone trying to gain entry to the building inappropriately. The service had also developed good links with the local police force and a PCSO attended residents meetings on a regular basis.
When we toured the building, we saw that hazardous substances such as cleaning solutions were stored securely in locked cupboards.

The service had a safeguarding policy which had been updated in line with the Care Act 2014, showing that the service kept up to date with any new legislation. We saw that this policy was on display in the reception area alongside the local authority safeguarding procedures which included contact addresses for local agencies. We saw from training records that staff had been trained in safeguarding adults from abuse and the staff we spoke with confirmed that they had attended these courses. They were able to explain types of abuse and the actions they would take if they witnessed or were informed of any allegation, for example, if they noticed unexplained bruising or changes in a person's behaviour which might indicate abuse.

The organisation's whistle blowing policy was on display in the staff room and staff were familiar with procedures to follow if they witnessed poor care or practice. We saw that where an incident had been reported to the manager relating to the alleged poor attitude of another member of staff this was taken seriously and action taken through the disciplinary process. In addition the organisation had a confidential helpline for staff to raise any concerns they might have. When we spoke to staff they were able to tell us that if they raised concerns these were listened to and appropriate action taken, including disciplinary action if required, and that when issues about their own behaviour were raised they accepted constructive criticism.

We looked at three care records which showed that risks to people's health and well-being had been identified. In addition to generic risk assessments covering such concerns as moving and handling and health and safety, further assessments, where appropriate, were completed in relation to food and nutrition, falls, or psychological risks, such as depression, social isolation, bereavement and loss. These detailed plans

considered the hazards and risks in relation to the person, task and environment and identified control measures to minimise or prevent harm. Assessments were reviewed on a three monthly basis, or sooner if any changes to the level of risk were identified.

The service took a proactive and person centred approach to risk and considered the needs of the individual within the wider context of calculated risk. For example, a person who liked to go out for a walk but was prone to getting lost was given a mobile phone with GPS tracker to take with them so they could be quickly located if needed. When they left, the building staff were encouraged to remind the person to carry the phone with them. This meant that the person could continue with their routines in the least restrictive and safest way.

The service recognised the variable factors involved in calculating risks, such as the person, the environment, the task and the circumstances. In one file we looked at the risk of bathing was reviewed prior to each bath time to ensure safe practices were followed.
Where a high level of risk had been identified any incidents were documented using an 'ABC' chart. This is a system to record the behaviours which led up to a specific incident; the incident itself; and any action taken following the incident. This system allowed for good analysis of risk and helped to put appropriate preventative measures in place to reduce the risk of further harm.

We looked at two staff files and saw that these showed procedures to ensure the staff recruited had the appropriate qualities to protect the safety of people who used the service. The files contained job descriptions, proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, a medical questionnaire, a job description, three references and interview notes. We saw there was a reference verification process in place: once a reference had been received, the service would contact the referee to check that they were who they said and that they had sent the reference. This was to ensure that the references suppled were genuine. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

There were enough staff to meet the needs of the people who used the service. Inspection of the staff roster and our observations showed there were sufficient, suitably qualified and competent staff available at all times to meet people's needs. When we spoke with staff they told us that they felt the staffing level was sufficient to meet the needs of the people who used the service. We saw that people received support from a small but consistent team of care assistants who worked well together and knew the needs of the people they supported. At the start of each shift staff would be allocated to work in one of two teams depending on the needs of the people who used the service. One member of staff told us "We have different characters but work as a team and support one another. If we have a problem we can call on the [other team] for extra assistance but that doesn't happen much. If we have a problem with other workers, we come together and try to work it out; we respect each other." The Senior Team Leader informed us that they did not like to use agency workers.

Staff files showed that where unsafe practices were found, appropriate disciplinary processes had been followed. Where issues of poor conduct were raised, proportionate action had been taken to reduce the risk. For example we saw evidence that medication errors were properly investigated and if found to be due to poor practice or inappropriate administration, disciplinary procedures were followed.

Staff on duty were supplied with 'dect' phones so they could request assistance from other staff within the home in the event of a crisis or emergency arising. Dect phones allow easy contact between people and all

staff carry a phone to enable a prompt response to any calls for assistance from either care staff or people who used the service. We saw that senior staff undertook 24-hour 'on-call' duties to deal with any issues which may arise and to ensure that staff were always supported.

When we walked around Adlington House we saw all communal areas were well lit, clean and warm. Walkways were free from any obstacles and an integral garage was used to store large items of equipment, such as mobility chairs and scooters, so that they did not obstruct rooms or passageways. There were no unpleasant odours. We saw infection prevention and control policies and procedures were in place, and that infection prevention and control training was undertaken by all staff. They gave a good account of the infection control and safety procedures they followed when providing personal care or helping to prepare meals. Staff had access to supplies of protective clothing including disposable gloves and aprons to reduce the risk of cross infection.

We looked at the documents that showed the equipment within the home, such as lifts, heating systems and appliances, were serviced and maintained in accordance with the manufacturers' instructions, ensuring there continued safety and suitability and the safety and well-being of everybody living, working and visiting the home. Health and safety procedures were followed and the organisation had policies to minimise risks to staff, such as a lone working policy to ensure that staff were safe. This included a system of 'buddy calls' for staff working alone at night: at regular intervals night staff would contact staff from similar services run by the organisation. If there was no response an alert would be raised and emergency procedures would be instigated.

We found systems were in place in the event of an emergency. There were fire risk assessments in place and we saw that personal emergency evacuation plans (PEEPs) had been developed for all the people who lived at Adlington House. These plans explain how a person is to be evacuated in the event of an emergency, taking into consideration a person's individual mobility and support needs. These were kept in each person's care record with a copy held in a central file that was easily accessible in the event of an emergency arising. The service also had a business continuity plan in place. This plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

People who used the service told us that the care staff were attentive to their health needs, and that they received their medication as prescribed. One person told us, "They sort my tablets out for me. I'm on a lot but they check and tell me what they are."

The service had a medication policy which took into account National Institute for Health and Care Excellence (NICE) guidance on medication management. This meant the service was keeping up to date with good practice guidance and supporting staff to ensure peoples medicines were managed safely. The policy was on display in the medication room. To ensure that people remained in control of their medicines, the procedures identified four levels of administration support, ranging from level 1, a person being fully independent and able to administer their own medicines, through h to level 4, where a person requires staff to administer their medicines. Where the latter occurred, best interest decisions were recorded and a detailed care plan was implemented. All medication levels were reviewed on a yearly basis or more frequently if any changes were noted.

All staff had been trained to administer medicines, and the Senior Team Leader undertook spot checks to ensure that they were dispensing or supporting people to take their medicines safely. This minimised the risk of errors occurring. When errors had been made, the manager would undertake a full investigation to understand the reason for the error and if required would implement disciplinary action.

We saw that there was a good system in place for managing medicines. All new medication was ordered and delivered from a local pharmacist. Once signed for by the registered manager or Senior Team Leader medicines were stored in an air-conditioned treatment room which was kept locked. The senior care worker on duty would hold the keys to the treatment room, with a spare set locked in the registered manager's office.

Both the fridge and room temperatures were recorded on a daily basis. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. There was also a signed log of all returned, unused medicines to the pharmacy to be safely disposed of. The Senior Team Leader conducted a full audit of medicines at the start of the week; this ensured that if a variance was discovered it could quickly be tracked and fully investigated. Where people had anti-coagulants, such as warfarin, we saw that careful attention was paid to the dose, the time of administration and records of clinic appointments. Highlighted notices such as reminders of when people who were taking anticoagulant medicines were due the next blood test were all kept in clear sight in the medication room, to minimise the risk of harm. Some people were prescribed medicines to be taken as required or 'PRN' e.g. paracetamol. We saw that close attention was paid to this type of medication with records showing the route (i.e., how it should be taken), the dose and the frequency. This allowed for better monitoring and review of any medicines given that were not required at all times. Medication administration records (MARS) were kept for each person who required prescribed medicines and contained a picture of the individual and clear instruction on the medicines needed. We reviewed three records which had been completed clearly and appropriately. Each file included a copy of the weekly audit; details of the medicines prescribed including patient advice leaflets; the MARS record and staff signatures.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These are called controlled drugs. At the time of our inspection nobody was prescribed any controlled drugs, so we asked the registered manager what would happen if they were. She explained that the medicine would be checked and signed in by two senior care workers, recorded on the persons record, as well as a controlled drugs register, and stored in a separate locked box. Before administering, safety checks would be carried out to ensure the correct person was receiving the medicine and that the right dose was being offered. Administering the medication would be witnessed by a second person, who would counter sign the records after the medicine had been given.

To improve staff knowledge and understanding of the medicines they were administering. The service would pick a 'medicine of the month' and made detailed leaflets and information downloaded from the internet available in the staff room for all staff to read, including side effects and methods of administration. This helped increase staff awareness, and improved their knowledge and understanding of the medicines they were administering.

Good

Is the service effective?

Our findings

People we spoke to were complimentary about the staff. One person who used the service told us "The staff are all excellent. They know us, and they know what they're doing. The perfect combination!" Everyone we spoke with told us they thought staff were well trained and competent. The relatives of a person who used the service told us that staff understood their parent, and how best to respond to their needs. They told us that although their parent could be difficult and sometimes demanding, staff remained calm and had developed ways of working in a way which responded to their mood, recognising the professional boundaries between care provision and befriending. Consequently this person had become more settled and at ease in their surroundings. They said that all the staff treated their relative with dignity and respect and they had worked hard to help their relative to settle at Adlington House.

We were told by the Senior Team Leader, "I like the staff to be well trained and confident before they're working on their own. We know our residents, and will notice if they are out of sorts." The registered manager told us that she believed it was crucial that staff were trained to high standards, and encouraged opportunities for learning. When staff commence employment with the service, they undertake a thorough induction, which involves a three day introduction to the service, allowing new staff to familiarise themselves with the site, the policies and procedures, and roles and responsibilities. Further learning was provided on food safety; fire safety; control of substances hazardous to health (COSHH); safeguarding adults and a one day course on moving and handling. Over the following twelve weeks new staff would undergo further training, including equality and diversity; mental capacity and record keeping; and further support relating to the people they would be supporting, specifically person centred care, medicine management, dementia and mental capacity. All new staff receive a performance review after one, three and five months and their competency is assessed before being signed of as competent at their six-month appraisal. Staff are provided with on-going training and encouraged to develop their knowledge, for example we saw that some staff were scheduled to attend further training on mental capacity the week after our inspection. The registered manager sought training opportunities from a variety of resources to further enhance the skills of the workforce, for example, training delivered by the local authority on safeguarding adults from abuse.

All staff either had completed, or were in the process of completing the Care Certificate. This is a professional qualification which aims to equip health and social care staff with the knowledge and skills which they need to provide safe and compassionate care.
The training matrix (record) showed that most of the staff had completed this training, with one relatively new member of staff on course to complete within an appropriate timescale. Staff were allotted time for training and development which demonstrated that the organisation was committed supporting staff to have the skills and knowledge to deliver high quality care.

The staff we spoke to told us that they received supervision at least every two months from the Senior Team Leader. One person told us that if they had a concern or if there was an issue with their practice, they could request further formal supervision. The staff files we looked at showed a thorough record of issues discussed, including any concerns or issues; personal; issues affecting work; information and reminders, and interpersonal relationships along with more clinical issues about service delivery. Reminders of the

importance of confidentiality were recorded along with the date of the next supervision session.

In addition, all staff received a yearly appraisal of their performance where their performance was assessed and objectives set for the following year. Progress against objectives set was reviewed after six months. If all objectives were met staff would receive a financial reward providing a further incentive to perform well.

We saw that there were regular 'handover' meetings between staff at the start and end of each shift. One member of staff we talked to told us that when arriving on duty and before the handover meeting they read the notes of people who use the service to catch up on any issues or concerns since their last shift, and this helps prepare them for their shift. We witnessed one handover meeting during our inspection and saw staff would provide an update person by person, and check any issues. Handovers help to ensure that staff are given an update on a person's condition and behaviour and should ensure that any change in their condition has been properly communicated and understood.

The Mental Capacity Act (2005) provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Care staff and the management team demonstrated a good understanding of this legislation and what this meant on a day-to-day basis when seeking people's consent. Staff told us they understood the principles of the legislation and how to apply this, including the need to apply to the court of protection if necessary. Further training had been organised for some staff to help develop a more in depth understanding of the processes as they applied to people living in their own homes.

Staff also had access to policies and procedures which had recently been updated. No applications had been made to the court of protection for any of the people receiving services at the time of our inspection, but we saw that some of the people who used the service had a Lasting Power of Attorney (POA). This is a legal agreement which allows a nominated person to make decisions on behalf of an individual if they lose the capacity to make decisions for themselves.

People told us they were supported to make their own decisions, and a member of staff told us that they respected people's decisions: "We do not want to take decision making and choice away from the person, and we like to give as much information as we have to allow people to decide". We saw that where people did not have capacity to make decisions for themselves best interest meetings had been arranged. This allows consideration to be given to the views of the individual, consultation with people who knew them well, including family members, social workers and doctors, and decisions made on their behalf were the least restrictive option. For example we saw a best interest meeting had been arranged to consider ways of preventing a person from causing themselves injury by tumbling out of bed.

People had consented for their photograph to be used on documents, for example their care plan and medication records. People had also signed to show they agreed with the care package and the support provided.

We saw that staff understood the importance of a good diet and ensured people had enough to eat and drink, including people who cooked for themselves. Cold drinks were available in the communal areas throughout the day, and we were told by one person who used the service that staff would check that they had sufficient to drink. This meant that people would not become dehydrated and had opportunity to have a drink.

People's dietary requirements were assessed and where appropriate nutritional needs were monitored and risk assessed. People could make their own meals or choose to eat their main meals in the restaurant, where

the catering staff were aware of their specific needs, and would check if people were missing at meal times. People told us they enjoyed the food provided, and we saw during our inspection that lunchtime in particularly was a social occasion and people would have an opportunity to meet and talk together. We saw one person who had moved to Adlington House on the morning of our inspection was welcomed into the community over lunch, and introduced to other people who used the service.

Where necessary the service would support people to maintain good access to health care. We were informed that the service has a good relationship with district nurses who call when necessary. One visitor we spoke to told us that the service liaised well with their relative's general practitioner (GP) and informed them of any changes to the person's medical condition. We saw in this person's notes that regular checks were conducted, recommendations acted upon and notes of any visits were recorded.

Adlington House was purpose built and designed to meet the needs of older people and people with physical and sensory difficulties. Corridors were wide and free of obstacles and obstructions; there were lifts to the upper floors fitted with folding chairs to allow for rest. Each person lived in their own apartment and decorated these to their own taste and preferences. Within the reception area there were easy chairs and coffee tables and we observed people gathering in this area to meet or discuss issues. Copies of resident meeting minutes were available to review. The building was equipped with a salon and hairdressing room, a well-equipped spa room, a large activities room equipped with pool table and board games room, a conference room and quiet lounges for people to meet or spend some peaceful time alone. One room was designated the 'jigsaw room' where a partly completed jigsaw attracted occasional visits from people who might add a few pieces. The restaurant situated on the ground floor was popular and well used by people who use the service.

Good

Is the service caring?

Our findings

People told us that they got on well with the staff. One person told us, "The best thing I have ever done was to come here. There isn't one member of staff I don't like; they are always pleasant and good to us". Another person told us "They know us. Daily care very good and person centred".

We saw a feedback form which stated "Nothing is too much trouble, I am treated with kindness all the time", and a reply to a questionnaire spoke of genuine care delivered in a friendly open atmosphere.

Relatives we spoke with also told us that they were made welcome when visiting the service. They informed us, and we saw that staff knew them and addressed them by their preferred name and were always welcoming. A relative told us that the staff were always available, friendly and knowledgeable. We were told that staff were "keen to get everything just so. They have a mentality of making everything perfect".

We saw that people were treated with kindness and compassion. People told us that they thought the care staff made an effort to get to know them, and staff told us that they felt that getting to know the people they supported was integral to their role. One member of staff we spoke with told us how they formed relationships with people who use the service, explaining how people needed to feel comfortable with the care being provided. This member of staff gave an example of how over time they had supported a person who was initially reluctant to allow staff to help them with personal care needs, exploring ways of meeting their need without compromising their dignity. They told us, "They need to be comfortable with us, so we go at their pace. We are always helping people with bits and bobs, and have time here to chat to people who use the service, even for just a few minutes. This way we get to understand them". By building up a relationship with the person they were able to develop confidence and trust.

We saw that people were treated with kindness and compassion. People told us that they thought the care staff made an effort to get to know them, and the staff told us that they felt that getting to know the people they supported was integral to their role. One member of staff we spoke with told us how they formed relationships with people who use the service, explaining how people needed to feel comfortable with the care being provided. This member of staff gave an example of how a person they supported with personal care was initially reluctant and how they built a relationship with this person to build confidence and trust Care records for people documented their interests and what they enjoyed doing. People told us that they were offered choice in the delivery of their care and support. We asked if people felt that they were involved in planning their care and the responses we received were positive, one person told us that they were able to "speak their mind, and that they were never excluded from decisions about them.

Staff were available throughout the day and night there was a good degree of flexibility in when care could be delivered. This meant if somebody wanted to have a lie in, or go to bed later, staff were able to respond flexibly to their needs. Staff could be contacted from anywhere in the building via the 'dect' phones., For example we saw that when a person wanted assistance to return to their room after lunch, staff were able to respond immediately and help them to go back in their own time and at their own pace.

We observed staff were vigilant to people's needs and treated people in a caring and compassionate manner. For example, we saw a care worker notice a person on their own and they went over to talk to them, sharing a laugh and a joke with the person. Privacy was respected and although staff had access to people's apartments for emergencies, they recognised that did not take liberties with this and would seek permission to enter. There were also areas on site where people who used the service could entertain their guests in private.

Staff formed positive relationships with people and demonstrated a good knowledge of their physical, social and emotional needs. People told us they thought the staff listened to what they had to say. One person told us that staff are "All nice and kind. If I want anything I can ask and it will be sorted out. It's the best place I've ever been".

There was evidence that people's wishes were taken into consideration in planning their care. For example, they could choose when they wanted assistance to have a bath, or if they wanted assistance to get up and dressed at an early hour this would be accommodated. Care records made clear what people required support with and what they could do independently. People and their representatives were encouraged to discuss goals about what they would like to achieve and they were encouraged to share in the three monthly reviews of their care plans. This helped them to remain independent and continue to have ownership, choice and autonomy in their own lives.

Some of the people who used the service held old-fashioned beliefs and values which are not acceptable in a modern multi-cultural and diverse society. The service employed a number of people from minority ethnic backgrounds, who reported that this has been a challenge when they recognise their duty of care even to people who held entrenched prejudicial views. They told us that by showing patience and understanding about set beliefs, and by questioning terminology and sweeping statements in a positive manner they have helped people to overcome their own prejudices.

Some people had advanced decisions, which stated how they would like to be cared for at the end of their life. These decisions were respected, and where possible people at the end of life were supported. However, it was not always possible to support people with complex medical problems and so individuals were supported to find alternative accommodation if necessary, and they would be supported through the transition.

Good

Is the service responsive?

Our findings

One person told us "They do everything they need to for me. Since I came here I've had a new lease of life. It's been fabulous. After I had an operation and needed more help, they were able to provide it without breaking stride".

The service provided care exclusively to people living within Adlington House, and was staffed over a twenty-four hour period and could offer bespoke packages of care to people who required support. We saw that the care provided was responsive to the needs of each and every individual and could vary from day to day depending on their changing needs. This meant that care and support was planned in co-operation with the people who used the service, and people who used the service were not tied down to specific times or fixed routines, and remained in control of their lives.

People could access services in a way and time that suited them. We saw that packages of care were negotiated with the individual, so they could vary from week to week. For example we saw that when a person was unwell for a period of time the care they received increased, and as they recuperated the amount of time required was reduced to ensure that the individual did not receive a service they no longer required. This meant that they did not become dependent on the service provision. This gave added peace of mind to the relatives of people who used the service. One visitor told us that they knew that if their relative became poorly, care was on hand and could be increased to ensure minimum disruption. They told us "They know her and her ways, they noticed a slight change and kept a close eye on her, called the doctor and he diagnosed an infection. All done very quickly".

We saw that services were delivered to people by a consistent team of care staff who knew them well. One staff member told us that they are encouraged to understand the person's background and culture, and that this helps to see the bigger picture: "We get insight into their lives. They are all individuals, so we get to know what makes them happy or sad, and we can respond to their mood". This staff member went on to talk about how they themselves respond: "We can't make assumptions, as each time we see them they might be a little different. Someone might generally prefer a shower to a bath but we will always ask to seek consent." They explained that they would phrase their questions differently to ensure that the person understood, and would talk them through each task, so for example, when assisting a person to shower they might ask "are you ready for me to rinse your hair?"

People's individual views were not only respected but also central to the planning of their care, and their needs and preferences were major factors in designing their care provision. One person told us that "They know me and know how to treat me as the person I am". They told us about their care plan: "It's tailored to my own needs. It addresses my whole needs, mind, body and spirit". We saw that the delivery of care was responsive to each individual and designed to meet their changing needs. So for example, medicines could be dispensed early in the morning if a person was going out on a trip, or later if they wanted a later call.

The care staff we spoke with recognised the differences between people in terms of background, gender and religion, and strived to respond to their needs through a person centred approach which reflected the

beliefs and characteristics of the individual. For example we witnessed a care worker sharing a joke with one of the more outgoing people who used the service whom they addressed by their diminutive name as they assisted them out of a chair, and shortly after the same worker was seen courteously assisting a person who used the service to put on their coat, addressing them with their formal name. Their response in both cases reflected the wishes and expectations of the different personalities of the two people.

We saw that individual's culture and beliefs were acknowledged in care plans. The service employed a chaplain for ten hours each week who tended to the spiritual needs of people of all faiths. This person organised a prayer group, which was popular with the people who used the service. This allowed them time for spiritual reflection.

Care plans identified and recorded people's individual needs providing detailed guidance for staff about how to provide consistent, safe and person centred care to ensure the well-being of each person, and were seen as part of an on going process of review. For the staff team, getting to know the people who used the service was a continuous process, and as they learnt more about a person, the new information was shared and added to the care documents. Staff recognised the value of the care plans and appreciated the time that they were given before starting work to read through and take note of any changes.

People were involved in planning and reviewing their care. Each person who received care and support had a copy of their care plan, and a further copy was kept in a file in their apartment, along with daily record sheets. We looked at four care plans, and saw that these were person centred and compiled in a way that provided a strong understanding of the person, so notes would indicate specific details about the person. For example, one such note read, "In emergency prefers to be taken to [X hospital] in preference to other hospitals". This person confirmed that this was indeed the case, and explained to us why this was the case. Care plans reflected the whole person and detailed physical, spiritual and emotional needs. They focussed on supporting people to meet their overall needs and detailed the level of support they would require to maintain their independence. Where tasks were identified these were clear with each task broken down to give detailed and specific instructions on what was required, such as the amount of sugar in tea, and gentle reminders to provide high quality care, such as 'take time to listen'; 'do not rush', etc. Where people had developed their own care routine we saw that these routines were respected and reflected in the person centred care plans. It was clear from our observations and from what we were told by the people who lived in Adlington House that people were encouraged to live the way they wanted to.

Staff maintained and kept up to date daily records recording interventions and noting any changes in peoples physical or mental health. These notes were regularly reviewed to determine if any patterns were emerging which might indicate a change in care needs, so for example, when one person became unwell we saw a change in the care plan as a response; further support was provided, regularly reviewed as the person got better and then discontinued after a full recovery. This meant that the person remained in control of his care; care was proportionate to need and minimised the risk that the person would become too dependent on support.
We saw that care plans were reviewed every three months with the involvement of the person and their family if requested, if there were any changes in need these were recorded as and when they occurred. An annual review was completed with each person, including a full review of all aspects of their care, including medication, all risk assessments, and documentation. This also provided opportunity for the service to receive feedback about people's level of satisfaction with the service This helped the service to better understand the needs of the individual and at the same time allowed opportunity for continuous improvement; the service recognised that by seeking critical feedback they could better understand how to improve the quality of care, and provide a more bespoke service which would deliver care in the way the person would want to receive care.

Accidents and incidents were recorded with actions taken to control risk, and details of people to contact in case of emergency were also clearly marked. The visitors we spoke to informed us that the registered manager was proactive in contacting them and would let them know immediately if anything out of the ordinary had occurred. They also let us know that they felt comfortable contacting the service at any time, and that staff were always able to provide the information they required.

Not all the people who lived at Adlington House received a personal care service but the service kept a log of all people who lived there and would check on anyone who hadn't been seen during the day. This meant the welfare of all the people living at Adlington House was being discreetly monitored, without infringing on people's personal choices. Everybody living at Adlington House could use their 'dect' phone to access care staff at any time during the day or night, and staff were on hand to respond to any emergency.

The service encouraged people to maintain a healthy and active lifestyle. One person told us that following a surgical procedure they were given a set of exercises to perform to maintain mobility. This person informed us that they received gentle encouragement from staff to follow the exercises and a carer would assist them. They told us that had they been on their own it was unlikely they would have had the motivation to do the exercises, but the support and encouragement offered helped the person to regain fitness.

When people move in to Adlington House they receive a 'Welcome Pack' detailing the services available, how to make a complaint, and the role of staff, including domestic helpers, maintenance and the chaplain. The pack also provides information about some of the activities on offer within the service and the local community. People were supported to follow their interests and maintain previous relationships. Visitors were encouraged and the service had a 'guest bedroom if visitors wanted to stay over a longer period than a few hours. This encouraged on going and continuous links with family and friends. We noticed a computer with internet and video facilities, and were informed that this was used by people to Skype (this enables you to see the person you are speaking with) relatives, particularly those who lived abroad. This helped people who used the service to stay in contact with their family and friends.

The service recognised the risks of social isolation. Friendship groups have been nurtured and encouraged to combat this risk, and the service has actively promoted and provided support for groups reflecting the hobbies and interests of the people who use the service, for example, book club, travel club; theatre club; social events such as whist drives and a regular film night. We also saw that other available activities were offered, such as art and Chinese painting classes, whilst each Monday there were dedicated board games, and a prayer meeting was held every Wednesday As one person told us, "My family said I was getting too grumpy and needed a place where I had company and medical assistance and they found me Adlington. All the residents are of a similar age ….and I have made lots of new friends".
Outside, a large and well-maintained garden also included raised flowerbeds, and keen or amateur gardeners who used the service were encouraged to maintain their interest by planting and tending to flowers and vegetables.

The building design of Adlington House allowed various activities to take place; we saw that there was a craft room, 'jigsaw' room and a sizeable lounge with a large screen television for showing films, football matches, or presentations from guest speakers.

The service actively sought the views of people who used the service and used the information to drive forward the quality. People who used the service told us they were listened to, and were asked for their views of the service when their care was reviewed and at other times, through feedback questionnaires or general customer satisfaction surveys. They also told us that the registered manager was very approachable

and if they had a problem she would listen and provide a response. We reviewed a recent survey sent out to family members of those people who received planned Domiciliary Care services, which showed a 78% response rate. Out of these, all the comments given were positive, such as 'respond well to emergency needs'; people feel listened to and 'explanations for action are always provided'. These comments reflected the positive comments we received from people who used the service and their relatives throughout our inspection.

A copy of the complaints policy was prominently displayed in the reception of the building and defined a complaint as 'an expression of dissatisfaction with any aspect of care or the facilities,' and detailed how each complaint would be handled. We saw that the organisation kept a log of complaints on a shared drive accessible by the registered manager (unless she was the subject of the complaint). She informed us that she reviewed complaints to see if there were any common themes which she could follow up and use as a learning tool, and that the service was keen to use complaints as an opportunity to improve the delivery of a quality service. We looked at the complaints log which showed no outstanding complaints; we saw that appropriate investigation, actions and outcomes had been recorded for each previous complaint, with copies of acknowledgement correspondence. Full and transparent outcomes were sent to the person making the complaint, with details of how to take the complaint forward if they were not satisfied with the investigation. The registered manager informed us that they take a proactive view of complaints and try to respond quickly to any concerns before they escalate. She told us that she kept an 'open door' policy, and we saw that she encouraged people to speak with her or inform another member of staff should they have any concerns. This meant that any issues of concern were quickly remedied.

We were told that there was a waiting list for people wishing to move into Adlington House. Before people are accepted the registered manager would undertake a thorough assessment to determine if the service was able to meet their needs. We were informed that quite often people were turned away because their needs were too great. Similarly, the scheme recognises its limitations, and whilst it attempts to support people to maintain their independence in their own home, the level of care that can be provided does not constitute nursing care. If a person becomes too ill to be cared for we were informed that the service would work proactively with health and social care professionals and with family members to support them to move to a different service.

Regular staff meetings were held and this gave staff the opportunity to comment on any changes they had noticed with people who used the service, and provide tips on what went well or badly when working with them. The service also had a 'knowledge box' in the staff room accessible by all the staff. Staff were encouraged to write down any useful pieces of information and record facts about the people they cared for. This helped to share knowledge. By sharing experiences in this way the care staff were continually building up a picture of how best to intervene when supporting people on an individual basis. One comment we saw said, "[named person] feels reassured when…" We spoke to a member of staff about this and they informed us a care worker stumbled across the information accidentally and that it had been particularly useful when the person began to become stressed or anxious. The knowledge box was also used to note information about external issues of interest, and if staff were aware of upcoming events in the community which might be of interest to the people who used the service this could be added, so staff could pass on the information to people who might be interested.

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Adlington House is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since July 2013. The registered manager was present throughout the inspection.

All of the people we spoke with were positive about the registered manager. One member of staff told us "I love it here, [the registered manager] is a fantastic leader in a good way: supportive, encouraging and nurturing. The atmosphere is great". This view was reiterated by a person who used the service who told us "The Methodist Housing Association staff under the guidance of [the registered manager] have created a real family atmosphere which is a pleasure to belong to." Another person told us that "She [the registered manager] makes the place work and leads by example; she will never ask anyone to do something she wouldn't do herself. A few weeks ago a night worker didn't come in so she did the shift herself."

Care staff told us, and we saw the registered manager and the Senior Team Leader were visible around the home every day when they were on duty. They showed a clear understanding of the role and responsibilities of the management team, and were aware of their responsibility to pass on to them any concerns about the care being provided. The registered manager told us information was passed up as well as down, and staff would inform her of any concerns or issues, and write these down to prompt any follow up action. This meant that the service had effective systems of communication. Information was delivered to the people responsible and timely action was taken to respond to the concerns.

The staff we spoke to were positive about the home, and felt that they were supported to do their job. One staff member explained that there is a learning culture within the service, and staff feel able to seek support when necessary, rather than try to 'muddle through' This person told us "Sometimes if I don't know I will ask, for instance I might not always understand the documents but they are patient and will go through it with me. This person told us that the managers were responsive to training needs and supporting the care staff to develop their knowledge and understanding both on and off the job. This learning culture mean staff were consistently building on their experience and developing new skills to improve the quality of service delivery. They were not afraid to ask questions, support one another, and were consistently acquiring a greater understanding of the people who used the service, and the systems and processes that ensured high quality care.

Another staff member talked about the teamwork within the service, explaining that the staff understand their roles and responsibilities to work for the benefit of the people who use the service. Whilst staff are often working on their own they will support one another and that "no-one is frightened of asking for help or support. We all need to help each other."

Adlington House is part of Methodist Homes and their statement of purpose regarding personal care is "to provide a bespoke and individual care service for anyone who has purchased the service". We saw this in practice. People and their personal belongings were treated with respect, and staff took time to get to know people's personal tastes and preferences. Staff responded to people's needs in a person centred fashion. We

saw that the staff and management team recognised that the older people who used the service could still lead full and active lives, develop new skills and maintain their interests. The service lived up to its values in seeking and providing meaningful activities and opportunities for the people at Adlington House. For example, as part of the assessment process the assessor would be asked to discuss opportunities for education opportunities for the person who used the service, recognising that age is not a barrier to learning. This meant people were given opportunities to learn new skills, and minimised the risk that people would become demotivated.

Quality of care was seen as integral to service delivery, and we saw that the service completed a 'values assessment', where the whole service was reviewed by the chaplain and people who lived at Adlington House to ensure that the service lived up to its values.

All the people we spoke with felt that they had opportunity to influence services and had a say in the running of the home. We saw that monthly 'residents meetings' were supported by the manager and staff, and well attended by people who used the service and their representatives. Copies of minutes from previous meetings were available in the reception area of the building. We saw that the local Police Community Support Officer (PCSO) regularly attended these meetings and other community representatives were invited. Residents meetings then fed in to an appointed 'residents committee', who would meet on a regular basis with the registered manager to discuss any issues of concern, and help drive forward improvement. The service listened to the people who used the service and followed up actions suggested by the residents committee, ensuring that people who used the service could influence the way it was managed.

There were effective systems in place to monitor the quality of the service. The senior team leader completed a weekly audit of medication and all care plans were audited every three months to ensure safe and appropriate delivery of care. Records were compiled to ensure any trends or emerging patterns could be identified at an early stage, for example, falls, accidents and incidents or safeguarding concerns, so that methods for reducing incidents reoccurring could be identified. Reviews and audits were thorough and comprehensive, involving discussion with staff and people who used the service, observations and analysis of records. Complaints and any allegations of abuse were thoroughly investigated and outcomes were monitored to provide opportunity for learning.

Copies of the company's policies were kept in the staff room where they were available to staff, and we saw that these were based on good practice guidance and up to date legislation. These included a communications policy, advocacy policy and study assistance policy, indicating a willingness to support staff to further their understanding and provide a better quality service. All policies were checked and reviewed annually. This demonstrated to us a desire to ensure staff had the most up to date guidance to ensure they supported people as well as they could. When we spoke with staff they showed a good understanding of the policies, especially the medication policy and infection control.

Staff told us that they were involved in discussions about issues of service provision during team meetings. Minutes demonstrated that they were encouraged to raise issues and take responsibility where mistakes had been made. The staff we spoke to told us they found team meetings useful, and felt supported to raise concerns and suggest changes they felt needed to be made. Team meeting minutes were displayed in the staff room and all members of staff signed these to say that they had read them. Staff were encouraged to pool knowledge and share information, for instance, there was a 'knowledge and questions' box. This allowed staff to contribute any thoughts they might have to improve the delivery of care, or add any information they thought might be useful for other staff either relating to the people who used the service or care in general.

We saw handover notes were kept together, and staff coming on duty were able to check back and read notes recording changes since their last shift. Notes were legible, signed and provided pertinent information and detail, for example "cream now finished, or observations: "mobility not as good today". As they began their shift, the care staff would have a full and up to date understanding of any issues or concerns about the people who used the service and could respond appropriately.

The service rarely used agency staff, and had recruited a small pool of bank staff retained to work on a casual basis, to cover permanent staff sickness or annual leave. This ensured continuity of care which was delivered by staff who were familiar with the people who used the service. People using the service and their representatives were given the opportunity to give feedback. We looked at the results of two recent customer satisfaction surveys, both of which had a high response rate and both of which gave positive comments, for example, '[the registered manager has] high standards and lead by example'; 'Exemplary standards in care and management' and '[Adlington House is] well managed, well run friendly and caring residential facility'.

We had a discussion with the registered manager about how the service worked with external agencies, such as the local authority and health services. She recognised that the service cannot work in isolation but on day-to-day issues most of the needs of the people who used the service could be met in house. They had developed a good working relationship with GP surgeries and worked closely with district nurses and other health staff. She informed us that the service recognised its limitations in providing safe care and support, for example, she told us about a person who was becoming more dependent on the care staff for her day to day needs. Whilst every effort was made to ensure these needs were met, the service liaised closely with the social work team and nurses to assess need for nursing care and supervision, and to seek a placement more suited to meeting clinical need.

Prior to our visit we contacted the local authority and CCG (Clinical Commissioning Group, this is the arm of health services that arranges for the delivery of health services). They reported that there had been no issues with Adlington House and were satisfied with the level of care provided.