Clacton Family Trust Limited

# Clacton Family Trust

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

The inspection took place on 9 and 10 November 2016 and was unannounced.

Clacton Family Trust provides accommodation and care for people with a learning disability and physical disabilities within a care home and supported living flats. The care home consists of five bungalows on one site. At the time of our inspection there were 37 people using this part of the service. Clacton Family Trust also provides personal care to people living in supported living units. People who use this part of the service have their own tenancies and receive the majority of their support from staff employed by Clacton Family Trust. At the time of our inspection there were 21 people living in supported living units. These were predominantly located in a purpose built property and the remainder in other properties within the local area. There were a further two people receiving support in their own homes.

A registered manager was in post at the service. 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.

When we last visited the service in 2015, we found people did not receive consistently good care across the service. People and staff in the care home had a less positive experience than in the supported living service. At this inspection we found the service had made significant improvements and people were now received good quality care and support across the service.

There was a new registered manager in post. Improved systems had been introduced to monitor the quality of the service and address poor practice. The manager demonstrated strong leadership and was committed to continuing the process of improvement through introducing innovation and best practice.

There was an open culture at the service and staff morale had improved. People who used the service, their families and staff were encouraged to speak about their experience of care to the manager. Concerns and complaints were responded to and dealt with promptly and effectively.

People were protected from harm. Staff knew what to do if they were concerned people were not safe. Risk was well managed across the service. Where people were assessed to be at risk there were practical and effective measures in place to keep them safe. When implementing these measures, staff were encouraged to minimise any restrictions on people.

The registered manager ensured there were always sufficient numbers of staff on duty to keep people safe. Staff were recruited safely and managed efficiently to enable people's needs to be met. Medicines were safely administered by appropriately trained staff.

Staff were skilled at meeting people's needs. They had received effective training and the manager was

proactive in ensuring staff had the necessary expertise, knowledge and attitude. Care plans were in place which provided staff with the necessary guidance to meet people's needs and preferences.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. The management and staff understood their responsibility in this area and promoted people's right to make choices about their care. Where people's freedom was restricted the manager had made appropriate referrals for authorisation to the local authority.

People were supported to have a healthy diet. They were encouraged to be involved in choosing and preparing their meals and drinks. People were supported to maintain good physical and mental wellbeing. Staff worked well with health and social care professionals to meet people's needs. Where people had complex needs, they had been referred for specialist support and guidance.

People were supported to have an active life and were encouraged to take part in hobbies and interests of their choice. Staff supported people to maximise their independence and develop new skills, particularly within the supported living service.

Staff knew people well and treated them kindly. People were encouraged to communicate their views. Where they had complex communication needs, staff were skilled at offering choice and enabling them to make decisions about the care they received.

## 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.

Staff knew how to protect people from abuse and risk was minimised across the service.

There were sufficient staff to meet people's needs.

Medicines were administered and stored safely.

### Is the service effective?

Good

The service was Effective.

Staff were well supported. There was effective training and guidance in place to enable them to develop the necessary skills to meet people's needs.

People were enabled to make their own choices. Where a person lacked capacity there were correct processes in place so that decisions could be made in the person's best interests.

Staff worked well with outside professionals to promote people's physical health and wellbeing. People were supported to have enough to eat and drink.

### Is the service caring?

Good

The service was Caring.

There were positive relationships between staff and people. Staff had respect for people's privacy.

Staff supported people to communicate their views.

### Is the service responsive?

Good

The service was Responsive.

People received support which was personalised around their individual needs.

Care plans described people's care and support needs.

People felt able to speak about any concerns they had.

## Is the service well-led?

Good

The service was Well Led.

The manager provided strong leadership and drove improvements in the service

Staff felt supported by the manager

There were systems in place to measure the quality of the service and deal with poor practice.

# Clacton Family Trust

**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 9 and 10 November 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist nursing advisor and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The nursing advisor was used to check that people's health and care needs were met in a safe and effective way.

On the first day of the inspection two inspectors and an Experts by Experience visited the care home. On the second day an inspector visited the care home and the supported living service. The nursing adviser visited the care home and an Experts by Experience made phone calls to people who used the service, and their families.

We met with the registered manager, the Head of the Board of Trustees and senior and support staff. We spoke on the phone to 13 family members and one member of staff. We contacted four health and social care professionals for their views about the service.

During our visit we focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

We reviewed all the information we had available about the service including notifications sent to us by the manager. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including the local authority. We used this information to plan what areas we were going to focus on during our inspection. We looked at ten people's care records

and six staff records. We examined information relating to the management of the service such as health and safety records, personnel and recruitment records, quality monitoring audits and information about complaints.

Good

# Is the service safe?

## Our findings

People told us or demonstrated from their actions that they felt safe at the service. People said, "I feel happy here, I like the staff" and "I can trust them." We observed interactions between staff and people and saw people were treated respectfully and appeared comfortable in the presence of the staff who supported them.

Family members told us they felt their relatives were safe. One family member said, "Oh yes. They are safe and secure. I think I'd know if [Person] was not right as they would show a temper… Person has staff round their little finger." Other relatives told us, '[Person] can let me know how they feel. They come home for a couple of days but now ask when they are going back" and "I visit regularly so I know what is going on and its safe. [Person] is very much at ease there…staff are kind and when I'm there I can see they also treat others very nicely."

We saw that staff had received training in safeguarding and were knowledgeable about the types of abuse people might be exposed to and how to report any concerns that they might have. Staff told us that they were aware of the whistleblowing policy and of their duty to report anything untoward to senior staff. The manager recorded and dealt effectively with safeguarding issues, including notifying us of concerns in a timely fashion.

Staff told us they feel well supported by managers and are able to discuss any concerns about the people in the care home. Staff comments included, "I would talk to the manager, and if I was still concerned I would contact CQC" and "I would go straight to a senior; write a report, I have reported issues from a previous job so I know what to do."

Staff offered people practical and non-judgmental advice to help minimise any risk to their safety. One person had been supported to attend an outside service which provided specialist guidance to help in the decisions they were making about relationships.

Risks to people's safety were assessed and reviewed regularly. Care plans included risk assessments in areas such as the environment, finances and accessing the community. For example, where there were concerns about a person's epilepsy, there was guidance on the appropriate numbers of staff and necessary equipment to ensure they could be supported safely out in the community.

Risk assessments were proportionate and centred around the person's needs. For example, where people had behaviours that challenged these had been clearly documented and included any possible triggers and the strategies of how to support the person when these events occurred. For example, where a person might throw items, staff were advised to check whether there were "any potential missiles available."

Restrictions were minimised so that people felt safe, but also had the freedom to access and participate in their choice of daily life skills. We saw the risk assessment for one person that included wearing head protection because of the person's epilepsy, during observations we saw staff supporting this person to put

the helmet back on after the person kept removing it. The staff communicated this clearly and in a supportive way.

People living in the supported living service tended to be more independent and many accessed the community independently. We were given examples of where people had moved between the two services to ensure they received the appropriate level of support to meet their needs.

A person who lived in their own flat and their member of staff described how they managed risk throughout the day. For example they told us what they did when they went shopping to keep the person's money safe. They demonstrated they had together negotiated how to balance risk and the person's safety.

Staff had a good awareness of risk issues. One member of staff told us, "I check who is in the house, whether they need one to one care and staff numbers; we check a variety of things to keep people safe, we are with people and have a supervisor around as back up."

Each person at the service had a personal evacuation and plan which clearly stated how they needed to be supported to leave the building in an emergency. One person in supported living told us they were supported to stay on their own in their flat and had carried out numerous fire drills. A person told us they knew what to do in an emergency and that they could not use the lift during a fire.

Staff worked proactively to reduce the risk of pressure areas. One person was at a higher risk of developing pressure sores so proactive strategies were in place to reduce this risk. The care plan stated that the person should be repositioned every two hours and the daily log notes clearly evidenced that this was being done and recorded adequately. Some people were using pressure relieving mattresses which were automated with an alarm system; pressure was calculated by assessing each person's weight.

Assistive technology was used to enhance people's independence. For example, in one of the units of the care home the kitchen had been locked but was now kept open. However people were kept safe as there was an alarm that was set off to alert staff if they walked into the room.

Staff were skilled in minimising risk when using equipment. A family member told us, "Staff need to help [Person] transfer safely and so far that's all done ok." Care plans outlined any equipment people needed and thorough maintenance checks were carried out, such as on wheelchairs, hoists and slings.

There was a range of monitoring systems which alerted staff to potential risk, for example some people's temperature was regularly checked. Accidents and incidents were logged and reviewed by the manager to check for any areas of concerns across the service.

There were enough staff on duty to meet people's needs and the deployment of staffing was well managed. A member of staff told us, "Staff levels now are really good, we had a massive change last year and everything is better." The manager told us that staffing levels were determined according to individual need, and some people received one to one care. Staff confirmed that they were specifically allocated to provide this support and we observed this support being provided, as required, during out visit.

Staffing in the supported living was deployed flexibly around people's needs and enabled people to live safely with the minimum of restrictions upon their independence. The manager described in detail the staffing at night time. Some people had one to one staff supporting them in their flats overnight whilst others had access to a member of staff who was on the premises, should they need support in an emergency.

There was an effective recruitment process in place for the safe employment of staff. Checks were in place to confirm that staff were of good character and suitable to work with people who needed to be protected from harm or abuse. Staff confirmed they did not commence employment until the necessary checks such as, proof of identity, references and satisfactory Disclosure and Barring Service (DBS) checks had been obtained. A review of records showed the appropriate pre-employment checks had been made. The manager told us they had recently stopped using agency staff due to the needs of the complex people at the service. If they had to use agency staff, they used two agencies and named staff only.

People's medicines were managed safely. People had risk assessments and clear protocols in place for the administration of 'as required' medicines and emergency medicines. Staff could only administer medicines once they had received the necessary training. They were then observed by a senior member of staff to ensure they had gained the necessary skills. A staff member told us observations were completed successfully before anyone could administer medicines independently.

We observed staff administering medicines and found them to be competent and respectful. For example, we saw staff explaining to people what was happening to them during the administration process. We looked at the medication administration charts completed by staff and noted these showed that medication had been administered to people as prescribed by their doctor.

Care plans offered specific and personalised advice about how to support people with their medicines. For example, one plan stated a person needed epilepsy medication one hour before they went to play football. There was guidance for another person if a person chose not to take their medicines. Where a person was not able to communicate verbally there was guidance in place for the signs that they were in pain and needed pain relief.

Emergency medication prescribed to people at risk of seizures was kept in a locked cupboard in individual coloured bags so staff could easily identify who they belonged to. The guidance for this medication was also kept with the medication so staff had this available when taking people out into the community. Where people were being monitored for oxygen levels, there were target levels and clear procedures for administration of oxygen, if necessary. Recording charts were in place and the procedure had been followed when oxygen levels fell below the target level.

The system for storing medicines was adequate to ensure its safety and all medicines were found to be within safe expiry dates. There were effective monitoring systems in place to ensure that the temperature of the clinic and the medicines fridge are maintained within safe limits. We checked a random sample of boxed medicines and found that the service was not always carrying forward previous stock balances, which meant we were unable to reconcile the records tallied with the stock of medicines held. We discussed this with the manager who readily put measure in place to address this.

The manager monitored the safety of medicine administration. They were pro-active about ensuring medication was prescribed as required and not used to manage behaviours inappropriately. They showed us an example where they had raised their concerns with outside professionals that medicines had been prescribed to control a person's behaviour. Staff had advocated on the persons behalf to ensure they were prescribed medications which appropriately met their needs.

Good

# Is the service effective?

## Our findings

A family member told us, "Yes, I think staff are well trained and they seem to know what they should do, how to deal with their epilepsy and how they should respond." Another relative told us, 'Overall I have a very favourable impression. [Person] is well fed and well clothed and looks good. I've never had to worry."

People were supported by staff who effectively met their needs. We observed staff supporting people and noted they had the skills and knowledge required when working with people who presented a variety of needs. We observed incidents where people became angry or distressed and saw staff knew what to do to support them. Staff interventions were swift and effective. Staff explained different approaches which they used. For example they described how, "[Person] likes water play so we can use this as a distraction."

Training records showed that staff had completed mandatory and specialist training, which included classroom and computer based training. Induction training was delivered using the Care Certificate; which is used to help care staff develop the core skills needed in their role. To ensure staff skills were maintained, key training was refreshed annually, for example manual handling, epilepsy and physical interventions courses were provided each year by the in–house trainer. Senior staff carried out observations to ensure staff had the necessary skills to support people.  -These observations included manual handling, dignity and respect, equality and diversity and nutrition.

Staff told us that they had also received training to meet people's specific health needs such as to enable them to support a person who lived with epilepsy. A member of staff told us, 'We get loads of training. Some of our clients have high level needs and it becomes specialist training, such as our use of oxygen."

The company policy required staff to have four supervision sessions a year. Records showed that staff members had on average only received one supervision session in 2016. However, monthly team meetings were held and the HR manager carried out drop in sessions at meetings. Staff told us that they felt supported and they could talk to the manager or supervisors at any time. One staff member told us, "I can ask to speak to any of the managers privately and all issues are dealt with." Another staff member told us, "I can request supervision at any time." The manager had already identified that supervision meetings were not being held as frequently as they should and had an action plan in place detailing all supervisions going forward.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met. We found that the manager had made appropriate DoLS applications to the local authority where people had been assessed as lacking capacity to be able to consent to their care. DOLS applications were personalised and related directly to specific restrictions on people's lives. There was a monthly audit of who was on DoLS and on the progress of any applications.

The manager ensured capacity was considered when making decisions which restricted people, such as the use of CCTV in the communal areas. Staff understood their responsibilities under the Mental Capacity Act, for instance, they knew they could not assume a person lacked capacity and to work in the best interests of a person. One staff member told us, "We ask people and we use objects of reference to support people with decision making." For example, if a person could not verbally tell staff what they wanted to wear, staff would show two items of clothing and ask the person to point to their choice. Staff were patient and did all they could to ensure a person could communicate their preference. A member of staff told us, "[Person) knows what they want, we offer the choices until we get it right."

Staff assisted or prompted people to have sufficient to eat and drink and to have a balanced diet. Where possible, people were involved in shopping, preparing and cooking their food. We observed staff taking people into the kitchen and opening up the cupboards for them to choose what they wanted for lunch.

At the care home many people were not able to prepare their own meal but staff took their views and preferences into consideration. One staff member told us, "Different people have different things for lunch, we find out what they want and prepare it, one person only likes rice dishes so we try to find different dishes with rice."

Lunch was relaxed and supportive, encouragement was offered and people who needed support received it. We observed a staff member support a person to eat, they took their time and did not rush the person. Another person sat at the table and ate their food independently. People were offered a choice of drinks and given enough time to make their choice.

When we visited the supported living service we observed a person making a meal with staff support. The person chatted about different 'Weight Watchers' recipes they were trying out. Staff supported the person in a relaxed manner but left detailed notes to their colleagues so there was a good oversight of how much the person was eating each day. We observed the member of staff maximised the person's independence by only intervening to give verbal guidance.

We saw that the service worked with health care professionals to support people with specific nutritional needs. For example, staff had received training and guidance from the speech and language therapists to support a person who had swallowing difficulties. Staff were able to tell us how much thickener to put in the person's drink. Where people needed a soft diet there was detailed guidance in place. There was also exact advice on the utensils to be used. For example, one person required a small spoon for meals and a beaker with two handles.

Some people in the care home received nutrition and medicines via a percutaneous endoscopic gastrostomy (PEG) directly into their stomach. Care plans contained general and specific information for staff to be able to understand how to do this safely and how to care for the PEG site. There were directions in the event of a problem with the PEG, such as an infection. Staff were observed administering medication and nutrition via the PEG. Consent was gained from the person, protective equipment was used and the process was calm and unrushed.

People had objectives set in relation to their nutrition and hydration. For some people this involved increasing their independence whilst for others with more complex needs there was guidance on expected fluid and food intake. Staff monitored how much people were eating and supported them as appropriate. A family member told us, "[Person] is overweight and they [staff] try to get them to eat better and be more healthy." People were weighed regularly so staff could check for any changes in weight. Where there were concerns measures were put in place. For example, a person had been referred to a specialist dietician.

Where care plans identified people at risk of dehydration and urinary tract infection (UTI), an eating and drinking plan was in place to monitor how much the person drunk throughout the day. There was evidence of fluid balance charts in use to do this. There was evidence of proactive strategies to decrease the risk of UTI, for example giving the person cranberry juice daily.

There was extensive involvement of health and social care professionals. Staff had worked with various agencies and made sure people accessed other services, such as GPs and social workers, in cases of emergency, or when people's needs had changed.

Advice and guidance was provided by external health and social care professionals and outlined in people's care plans. This meant staff had the correct information available to work with professionals to ensure the individual needs of the people were met. For example, there was specialist advice from a speech and language therapist (SALT) to help staff communicate with people. A health professional told us, "What we try and put in place here happens."

Where people had epilepsy, there was a clear protocol in the care plan with description of seizures and a flow chart displaying the process for caring for the person during a seizure. Seizure monitoring charts were in place to record the frequency, duration and description of the seizure to support assessment and medication reviews.

People were encouraged to be involved in decisions about their health. We observed a person asking about a GP visit. Staff explained this was an annual health check and we noted they communicated in a way that was appropriate to the person's level of understanding.

Each person had a document which could be used if they were admitted to hospital to provide advice to health staff. For example, one person's advice said they would be frightened if they heard loud noises. Family members were positive about the continuity of support people with complex needs received when they were in hospital. Family members told us, "I've been very impressed. I've had phone calls if there is any problem and when [Person] has spent time in hospital the carers sit with them" and "They go with him if he goes into hospital. It's a relief that we have this support."

Good

# Is the service caring?

## Our findings

People and their families told us staff treated them kindly. A family member told us, "The carers look after [person] lovely and it's nice to know they are well looked after and have everything they need."

Staff knew people well and spoke in a positive and caring way about the people they supported. They told us, "[Person] really loves going on the bus to Colchester, they are such a character", "[Person] can walk for miles, they love being outside" and "[Person] likes Elvis and old cars." The language in care plans demonstrated a fondness for people, for example one care plan said, "[Person] likes to laugh, so acting a bit silly doesn't go amiss as they get you are messing about." We observed people had good relationships with staff. For instance, people who spoke very little smiled when they saw a member of staff. Staff had good eye contact and appropriate use of touch when supporting people.

People benefitted from having staff with an in-depth understanding of their individual needs and preferences. Care plans contained an 'All about me' and recorded details about people's life, their likes, dislikes, and personal preferences. For example, we saw in a person's care plan that, "[Person] would like her room to be decorated pink," and when they showed us their room, the walls and accessories were all pink.

We asked staff to describe the different ways they supported people with communication. One staff member told us a person used an eye-operated communication computerised system to communicate and interact. Staff had learnt to recognise non-verbal forms of communication to ensure people's views were taken into consideration. We observed a member of staff asking if they could open the curtains in a person's bedroom and acknowledging the person's gesturing 'no'. We saw one person using a sign to ask staff for a coffee, they tapped two fingers on their mouth and head, we checked the persons care plan and this sign was clearly recorded. A family member told us, "[Person] will grab things and the carers know what they want and are pretty good at reading their feelings."

Some people had been in the service for many years and staff knew them well. The manager told us they recognised this meant routines had on occasion become fixed and so they were introducing "objects of reference" to aid choice. So for example, if a person was not able to say whether they wanted a bath, staff would show them a flannel and use this to communicate with them. Different objects would then be used to offer choice to give people more control over their care. Whilst we observed that some staff were already using this form of communication, promoting this good practice would support people to have a more active role in determining their care.

Some staff used pictures to communicate with people but the manager acknowledged there was scope to develop more creative methods of communication, in line with best practice. Care plans were being improved to make them more accessible and easy for people to understand. One member of staff described enthusiastically how people's future plans would be personalised with photos which would be meaningful, such as a picture of the specific bus used to go to a college course.

Staff understood the importance of family and people were supported to have contact with family members. A person told us staff supported them to visit their family regularly. A family member told us, "I was down there last week and [Person] was in good form. - We had a party and a bit of a feast…. Kentucky!" Staff had made special arrangements which supported a person to have their family to stay over in their flat. Another person's family struggled to visit them at the service so the person had been supported to visit their family home.

Staff were able to provide examples of how they respected people's dignity and privacy and treated people with compassion when providing them with care. A staff member told us, "We use people's rooms (to provide care) and shut the doors and curtains." When staff spoke with us they were respectful in the way they referred to people. Staff spoke about promoting people's welfare and well-being. The approach of the staff we spoke with was person centred. One staff member told us, "Staff here really care about people." Another staff member told us, "[Person] is fantastic; I really enjoy working with her."

We observed however that some staff addressed the people they supported as 'girls' and 'boys'. We raised this with the manager, who acknowledged these terms did not support people to be treated as adults and agreed to address this with the staff team.

People were treated with dignity as staff communicated with them at a pace which was appropriate to their needs. Staff gave people time to process what was being discussed and gave them time to respond appropriately to ensure people were engaged. Some people required one to one support in certain situations, such as mealtimes, due to risks arising from their needs. We observed this one to one support was provided in a non-intrusive and respectful way. People were enabled to move freely and were not restricted by the staff who supported them.

We were given examples of where staff had arranged for advocates for people. An advocate supports a person to have an independent voice and express their views. For example, when a person had asked to move out of the service they had been supported by an advocate to ensure their views were considered. Another person had been supported by an advocate when they needed to make an important decision about whether to have an operation.

We also saw examples where the manager had advocated on behalf of people to enhance their quality of life. The manager had not accepted the status-quo when they felt more could be done for the person. This demonstrated a commitment to advocating for individuals who might not otherwise be listened to.

Staff were observed supporting a person who was showing signs of minor distress or pain. Staff communicated carefully and respectfully with the person to systematically identify where the pain was located and then offered pain relief to the person. Through a commitment to minimise pain staff demonstrated a compassion and commitment to people's wellbeing.

Where end of life care was being provided staff had considered people's views and there was evidence of involvement from advocates, family members and outside professionals, as appropriate. A support organisation specific to a person's culture and religious beliefs has been consulted and practical advice has been given to the support team about end of life.

Good

# Is the service responsive?

## Our findings

People told us about a variety of things they enjoyed about where they lived. For example, they said, "I'll be going to buy some jumpers soon" and "I can have a rest on my bed after lunch and watch a film." Family members told us, "The carers are very professional. - They do though keep us in the picture and when we go we get all the details about [Person]. We visit fairly often and they look well looked after" and "I'd give them full marks. It's high level care, it's been wonderful. [Person] is now signing more and the carers are working with them better and go out more."

In our last inspection we felt people had not consistently been supported to engage in meaningful activities. At this visit, we found people received consistently personalised care and support and lived full lives.

Assessments of people's needs were carried out prior to people starting at the service and were reviewed regularly. People's care and support was set out in a written plan that described what staff needed to do to make sure that personalised care was provided. When initially planning care the support plans took into account people's history as well as the activities that were important to them.
It was evident from people's daily logs that care plans were being followed by staff and recorded in an accurate and timely way.

Where people had complex needs care plans provided sufficient guidance to meet their needs and we observed that staff supported people in line with this guidance. For example one person had a specific care plan for how the person preferred to be supported at night. This included preferences for positioning, moving and handling and their routine for settling to sleep.

Relatives and external social care professionals were involved in developing support plans to ensure all the person's needs, wishes and wants were taken into consideration. Where possible, people had been involved in the planning of their care and at reviews of their care and support.

Care plans were being revised within the supported living service to demonstrate where people were progressing and meeting specific outcomes. For example, some people were aiming towards getting a job or attending college. The service had worked with the local authority to implement these changes.

We saw these care plans emphasised the importance of promoting people's independence by recognising their strengths and what they were able to do for themselves. Where appropriate care plans had clear targets to support people to develop their independence. This was being done gradually, for example where a person aimed to be more independent with their eating, staff were supporting them by introducing any changes during snack times.

Some people were able to describe how they were already more independent than when they had arrived at the service. For example, one person in the supported living told us they were now able to make a sandwich independently and were able to stay safely in their flat on their own for a set period of time. A key part of the work carried out by staff involved communicating with relatives as their family members became more

independent.

The manager told us they were involving people in the supported living service in a review of how the service was provided. Each person was given the opportunity to say what staff they wanted to support them and what they liked or disliked about the current arrangements. We saw the personalised timetable of support being created around one person which was tailored to their needs and preferences. It showed that when their usual worker was off which member of staff they had chosen to cover.

The service supported people to lead meaningful and fulfilling lives. We observed that people were engaged in a variety of occupations and staff were encouraged to develop these flexibly. One person showed us their nails which had just been painted. Another person was doing some exercises with staff and had put music on to make this more enjoyable.

Staff were observed to be making Christmas decorations with a group of people. Although, some people were not physically able to take part in this activity, staff regularly engaged them by seeking their opinion of the colour and including them in conversation. Staff chatted about things that were relevant and of interest to people such as music and people's family life.

A member of staff described how they supported a person, "They love repetitive games like connect 4, we go for walks and will use sensory music. We are trying to organise a holiday to Disneyland Paris at the moment." A family member told us, "[Person] does not get bored and keeps busy. They go out a lot and they keep having things to do and aren't stuck indoors." Staff told us that some activities were planned but others just happened if the person decided they wanted to go out. There were two minibuses to enable greater flexibility. We observed a person was able to use the transport to attend a GP appointment and still go to their day activities at a later time.

People were supported to be integrated into the local community. For example, one person worked in a charity shop and another was a volunteer receptionist. We were shown an example where a person had specific needs around the relationships they chose to develop both within the service and in the local community. Staff demonstrated a holistic approach to the person's needs, respecting their wishes whilst supporting them to stay safe. They treated them with dignity and had made appropriate referrals for support from specialist organisations. Staff had detailed guidance to follow when supporting the person, which were shaped by the person's views about how they wanted staff to work with them.

People's religious beliefs and cultural needs had been considered and catered for. Care plans gave directions regarding the specific gender of staff support and how a person wanted to be dressed in accordance with their cultural preferences.

When we spoke to people and their families they told us they did not need to complain but said they could get things sorted out. We were told when complaints happened they had been taken seriously and had been acted upon. The manager was proactive about resolving issues and regularly met with family members to discuss and resolve concerns.

Complaints were logged and used to improve the service. For example, where concerns had been raised during recent individual reviews at the supporting living service, the manager had met with members of staff to address the concerns raised. This demonstrated the views of the people being supported were used to drive improvements.

Good

# Is the service well-led?

## Our findings

When we last inspected the registered manager had just left the service. Since that visit the former deputy manager had been appointed as the new registered manager. Therefore, although there had been a period of disruption, there had been some continuity for people using the service and the staff team. The new manager had comprehensively and positively responded to the issues we had raised at the last inspection. We found there was now a more structured approach to the management of the service and improved systems in place to ensure people received a consistently good service. The manager had demonstrated strong leadership after the last inspection and some staffs employment had been terminated because of poor performance.

The manager described how during the last year they had focused on key priorities such as, improving staff morale and ensuring people received safe care of a good quality. They were now intending to focus on adopting best practice, such as involving people who used the service in staff interviews.

The new manager had improved the on-going checks they carried out across the service. The new systems were clear and thorough. We saw that people's quality of life was improved as a result. For example, all care plans had been audited to highlight any gaps in people's care. As a result, a person who was losing weight had been referred to a dietician and another person to the dentist. There had been meetings with staff following audits to highlight where improvements were needed, for example in their daily record keeping. The manager told us they were preparing to launch a programme of "mock inspections" which they would use to help monitor the quality of the service.

Staff told us that there had been improvements in staff deployment since our last inspection. The manager told us they had reinstated a team leader into each unit of the care home. We observed senior staff frequently interacted with people in the service and responded promptly to any requests from staff or people. The manager described how they also worked on a some shifts to assure themselves there was sufficient staffing to keep a person safe and support was being provided in line with their needs.

The manager had an open relationship with families and could describe how each family member chose to interact with the service. For example, one parent visited twice a week and spent time talking to staff and reading all the logs which staff had written. There was evidence of contact with families in people's records. There was a family forum, which was incorporated with a social event to help welcome families to visit the service. A family member told us, "The care [Person] receives is excellent and they are very happy there. We are kept informed, we are very satisfied with the service."

Staff told us that they were well supported by the registered manager of the home. They told us the registered manager was always available if they needed to speak to them. Staff members told us, "[Registered manager] is brilliant, she's sorted everything and she gets things done" and "[Manager] gets things done, some people ask to speak to them personally and they always respond." Staff meetings took place regularly, for example in each individual unit of the care home or supported living service. They were used to improve the quality of the service for people, for example the manager reminded staff not to walk

unnecessarily through people's lounges as this was an issue of privacy. A member of staff told us, 'We have good communications with colleagues and each other, we have an open door and I've used it before now. And we have regular staff meetings."

The manager demonstrated a commitment to resolving on-going challenges over recruitment. Changes had included improving conditions, enhancing training opportunities and revising the job description. As a result, the manager told us the service had improved its reputation and there was increasing interest from applicants.

The manager had an excellent grasp of the requirements of the different parts of the service. They described the specific skills needed to support people who had their own tenancies. Since the last inspection the manager had developed separate job descriptions for each part of the service to ensure staff with the most appropriate skills were recruited.

The manager demonstrated strong leadership as they balanced conflicting priorities as the organisation evolved and developed. We spoke to the head of Trustees to discuss plans for the future and to ensure the existing manager would not become overstretched. There were clear plans in place to support the registered manager, for example to move the administrative office closer to the care home and to appoint additional senior staff as the service expanded.

The manager worked closely with the local authority to involve them in the development of the service. We spoke with representatives from the authority who told us the service worked positively with them to address any concerns raised. The manager had also worked jointly on a project to support people who might be frightened to go to hospital. This involvement demonstrated that the manager was consulting with outside professionals when they developed the service, and ensuring changes responded to the priorities in the local community.