Links South West Ltd

Cedar Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Cedar Court is registered to provide personal care and support to 13 people in two separate semi-detached houses. People living at the home are younger people with a learning disability or autistic spectrum disorder. When we inspected the home there were 8 people living there. The building is made up of supported but semi-independent flats and more traditional residential care rooms to meet people's needs.

The home had a manager in post, but they were not yet registered with us. They are referred to throughout the report as the manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

This inspection took place on 10 May 2016, and was unannounced. During the inspection we found some positive practice in place, and some areas where the home needed to improve.

Risks to people had not all been reviewed or updated since the person had moved to Cedar Court. Staff had positive approaches to risk taking, but some of the information in people's files was from previous places where people lived, which meant it may not be accurate or up to date. People had been encouraged to be involved in decisions which affected them, and in writing their care plans. However not all the care plans were up to date or reflective of people's care at the time of the inspection.

Staff training and support needs had not always been identified or met. Staff spoke passionately about their work and the people they supported, and we saw evidence of positive, caring and supportive relationships. But staff did not all have the up to date knowledge or skills needed to support people with their needs. Gaps in care planning and records meant this presented a higher level of risk as staff could not use these with confidence to support people. We have made a recommendation in relation to staff training and support systems.

People were protected from the risk of abuse as staff understood the signs of abuse and how to report concerns. People benefited from sufficient staff to meet their needs, and staffing levels were increased to meet their wishes regarding activity. However systems were not in place to manage any risks associated with the staff recruitment process. The staff team were clear about and were encouraged to work within the ethos and philosophy of the home. The home had a strong, visible person centred culture and was good at helping people who used the home to express their views. People were encouraged and supported to engage with the local community. Where people had raised concerns these were managed well.

People received their medicines as prescribed. The systems in place for the management of medicines protected people who lived at the home; however we identified some concerns that prescriptions were not always clearly written. The manager agreed to clarify these with the prescriber to ensure they were being given at safe intervals.

Accommodation was personalised and had been adapted to suit individual people's needs. Some people had their own flats which they were able to personalise. Other people had more traditional residential care accommodation. Movement between the two semi-detached houses, which might be necessary to enable people to access the central kitchen was managed through the use of electronic key fobs.

People had access to the healthcare services they needed, including a staff having a clear understanding of when emergency care was needed for one person. The home had thought about people's needs and relatives were being involved in making best interest decisions where people needed support in making decisions. Appropriate applications had been made under the Deprivation of Liberty Safeguards to help protect people's rights and safety.

There were some systems and audits in place to assess and monitor the quality of the home, but these were not all robust. The quality assurance system had not been fully completed, and some records were not comprehensive enough or well maintained. Some records were not well maintained, and systems for the management of risks were not always ensuring people's safety. For example, the laundry systems at the home did not provide a safe system for the potential control of infection. We have made a recommendation in relation to the systems for control of infection at the home.

We identified a breach of regulations during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

Information on risks was identified, but had not all risk assessments had been reviewed since the person had moved to Cedar Court. Staff had been given some information on how to manage risks to ensure people were protected, and had positive approaches to risk taking. Some recording of incidents was inconsistent which meant that action could not always be taken to reduce a re-occurrence.

People were protected from the risk of abuse as staff understood the signs of abuse and how to report concerns.

People benefited from sufficient staff to meet their needs. People's care needs were reviewed and staffing levels increased to meet their wishes regarding activity accordingly.

Recording systems were not in place to manage any risks from the staff recruitment process.

People received their medicines as prescribed. The systems in place for the management of medicines were safe and protected people who used the home. However some prescribing instructions were not clear, and the manager agreed to discuss these with the prescribing GP to ensure staff were clear about safe intervals for administration of medicines.

The laundry management systems at the home did not provide a safe system for the potential control of infection. We have made a recommendation in relation to seeking advice on infection control practices.

Is the service effective?

Requires Improvement

The home was not always effective.

Staff training and support needs had not always been identified or met. Staff did not always have the updated training they needed to meet people's needs. We have made a recommendation in relation to staff training and support

systems.

People had access to the healthcare services they needed, including a clear understanding of emergency care.

Accommodation was personalised and had been adapted to suit individual people's needs.

The home had thought about people's needs and relatives were being involved in making best interest decisions. The home had made appropriate applications under the Deprivation of Liberty Safeguards to help protect people's rights and safety.

Is the service caring?

Good

The home was caring.

Staff were positive, kind and caring and people were treated with dignity and respect.

Staff spoke passionately about their work and the people they supported. We saw evidence of positive, caring and supportive relationships.

The home had a strong, visible person centred culture and was very good at helping people who used the home to express their views.

Is the service responsive?

Requires Improvement

The home was not always responsive.

People were encouraged to be involved in decisions which affected them, and in writing their care plans. However not all care plans were up to date or reflective of people's care at the time of the inspection.

People were encouraged and supported to engage with the local community and develop new goals to promote their independence.

Complaints were managed well.

Is the service well-led?

Requires Improvement

The home was not always well-led.

The manager of the home was not yet registered.

The staff team were clear about and were encouraged to work within the ethos and philosophy of the home.

There were systems in place to assess and monitor the quality of the home, but these were not all robust. The quality assurance system was used to develop and drive further improvement, but this had not been fully completed.

Records were not all well maintained.

Cedar Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

This inspection visit took place on 10 May 2016, and was unannounced. One social care inspector carried out this inspection.

At the time of our inspection, eight people were using the home. We used a range of different methods to help us understand people's experience. We spoke with six people living at the home, and four relatives. We also spoke with five staff, and three members of the management team, including two directors of the provider company. Following the inspection we received information from agencies who had placed people at the home and the local safeguarding team about how the home operated.

We looked at four people's care plans, medication records, three staff files, audits, policies and records relating to the management of the home. We looked around the environment and discussed future plans for the development of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and would talk to staff if they had any concerns about living at Cedar Court. One person told us about how safe they felt at the home. They told us they had previously had poor experiences, but said of Cedar Court "I feel really safe here now. I really love it here, it's the best". A relative told us they did not feel their relation "could have been looked after better anywhere else" and felt staff understood what actions to take to help protect the person's health and keep them safe.

Risk assessments were documented in each person's file. However some of the risk assessments related to and had been completed by previous services the person had been living in. They had not all been reviewed or updated by Cedar Court, even though they may still be current risks, for example risks from smoking. Other risk assessments had been provided and updated for people, including for travelling in vehicles, use of communal and shared spaces and slips, trips and falls. This told us that the processes of risk assessment and mitigation were not always thorough or consistent.

Staff demonstrated a positive approach to risk assessment and risk taking as ways of enhancing people's life experiences. Staff understood the risks associated with people's behaviours and how to support people in positive ways. One staff member told us "Living a valued life includes being able to take risks and make bad decisions. Managed risk is what risk assessments are for. I used to think of them as barriers but they are a tool". There was guidance available for staff on how to manage most significant risks presented by people, for example how to support them in case of distressed or anxious behaviours. This included de-escalation and distraction techniques, and was based on positive behavioural support principles. Staff understood how to support people when they were distressed or agitated and how to ensure people's physical boundaries were respected. Staff had received training in appropriate physical techniques to reduce risks to the person or others around them. However staff told us this had not been needed as they had been able to intervene with positive approaches and de-escalation techniques.

Although systems were in place to identify and record incidents and forward these for review to the manager, there was no consistent system in place for analysing and identifying patterns to prevent a re-occurrence. We asked to see a monitoring record that had been referred to in one person's daily notes as having been completed to record an incident, but this could not be located. Another person had an epilepsy monitoring sheet that had been fully completed by staff in detail and this was used to identify any significant changes in their seizure activity. However another epilepsy record had not been updated to reflect the person's recent seizure activity, meaning the two records were not consistent. The provider told us this was because the document had only been recently introduced.

All areas of the main building seen were clean. However the laundry area situated in an outside garage needed attention to ensure that any potential infection control risks could be managed. This included ensuring proper systems for the separation of clean and potentially contaminated laundry, and providing wall and floor surfaces that were easy to keep clean. Some non-laundry related items such as old furniture, ladders and vegetables were also being stored in this area, which would be used by people living at the home as well as staff. The provider has told us this area would benefit from redevelopment and this was

reflected in their action plan. We recommend the provider seek guidance from a reputable source on safe systems for the control of infection in laundry areas.

People were being protected against the risks associated with medicines. However, we found that one prescription had not been clearly written to include a minimum time period between doses. The manager agreed to review this with the prescribing GP. Medicines were being reviewed regularly, and protocols were in place to clearly record when medicines to control seizures should be administered.

People's medicines were stored safely and securely. For some people this was in locked cupboards in their flats, but for others this was kept centrally in a lockable trolley. Staff who gave people their medicines had completed training to enable them to do this safely. Some people partly managed their own medicines, for example inhalers, and these were monitored to ensure that people were not using these excessively. Records of medicines administered confirmed people had received their medicines as they had been prescribed by their doctor to promote good health or manage long term health conditions.

People were protected by staff who knew how to recognise signs of possible abuse. Staff had not all received recent training in how to recognise harm or abuse, although those we spoke with had done so under a previous employer. However, they knew where to access information if they needed it and told us they would not have any concern about raising any issues with the home's management. They felt the manager would listen to their concerns and respond to these. The home had policies and procedures in place for staff to raise concerns without reprisals. Although the home did not have anyone living at the home who was under the age of 18 they had told us they may do as people transitioned between adult and younger people's homes. The home was accessing a copy of the local authority Child Protection procedures and told us both adult and child protection procedures formed a part of their training programme for staff. At the time of the inspection the home was involved in an open safeguarding process about one person.

There were sufficient staff on duty to meet people's needs. People living at the home had a contracted allocation of one to one time, based on risks and their individual needs, which varied for each person. We saw that the appropriate staffing levels were identified, based on each person's preferences and wishes and records showed that this was provided each day. Staff times were flexible, based upon what each person said they wanted to do that day. For example staff might start working later as the person they were going to support wanted to take part in an evening activity. The manager reviewed people's care needs regularly to ensure staff had the time to support them, and staff told us they did not work with people whose needs they could not meet. For example one person had a long term health condition that might require emergency medicines to be administered to them. A staff member told us they would not be expected to support that person until they had undertaken specific training to manage the condition. We were also told that there was a heightened awareness of staff becoming over tired supporting individuals who had high levels of need. A senior staff member told us in that instance staff duties would be changed around to give them a break.

Safe staff recruitment procedures were in place. Staff files showed evidence that pre-employment checks had been made including written references and satisfactory disclosure and barring checks (police checks). Evidence of staff identity had also been obtained. Some staff had been directly approached to work for the provider at Cedar Court, as they were aware of the skills they had in supporting people. However we identified there was no formal recorded system for risk assessing any declared convictions staff may have. The manager told us they would discuss any issues with the staff concerned and make an informed decision. The provider was recommended to ensure that any risks associated with the staff recruitment process were fully risk assessed and recorded.

The premises and equipment were maintained to ensure people were kept safe. For example, checks had been carried out in relation to fire, gas, and electrical installations. The home's handyman told us any maintenance issues were written in a maintenance book for him to address. Some people who lived at the home displayed destructive behaviours at times, including damage to furnishings and fittings. Efforts had been made to protect people from risks associated with this, for example with fitting metal light switches and the design of furnishings. Each person's private area had been designed specifically to meet their individual needs. Hot surfaces were protected and window openings restricted. Some lower windows had protective film to protect people's privacy while in their personal space. Water temperatures were restricted and items that could cause potential harm were secured away.

There were arrangements in place to deal with foreseeable emergencies. For example, there were emergency plans for fire, loss of heating, loss of electrics, and gas leakage and the evacuation of the building. Regular maintenance contracts were in place for example for the maintenance of fire equipment.

Requires Improvement

Is the service effective?

Our findings

We spoke with staff about the training and support they had received, and looked at three staff files.

We found that staff had not always received the training and support they needed to carry out their job role. The home's management did not have a system for ensuring that staff had the training and skills they needed to carry out their job role. For example the manager told us they had not carried out an overall training needs analysis or plan for the home, but that individual training records and certificates were kept in each staff member's file. We found there were gaps in the staff core skills training records in the files, for example most staff did not have training recorded in safeguarding, infection control or first aid. None of the files we looked at could evidence training in supporting people with Autism, although there were people with significant autism living at the home. We checked with staff and found that although some training had been carried out with previous employers, much of this had lapsed.

Staff were receiving supervision, but although this identified the training staff had done it did not including a training need analysis for the individual. The manager told us "I was aware this was something we needed to work on". Additional administrative support had been recruited to support the manager to develop systems for assessing training needs as a result, although this had not yet started.

We recommend that the service identifies staff training needs and sources training for staff, based on current best practice, in relation to the specialist needs of people living at the home and tasks staff need to carry out as part of their job role.

Staff told us they had completed a general induction to the home and six staff were completing the Care Certificate, which was a national qualification for staff at induction level. Some staff had other qualifications such as degrees in Health and Social Care management and were undertaking diploma qualifications which would cover some areas of the missing core competencies, however this was not identified in their records. Staff also told us that they had learned informally a great deal at the home through watching senior staff and management modelling effective and supportive care. One told us "This is a great place to learn". When supervision had been delivered to staff they had found it effective. One staff member told us a recent supervision session they had was really helpful to them. They told us it had been very insightful, challenging and had helped their personal and professional development.

Staff told us people were encouraged to make choices about their meals and for some people this meant being supported to budget and plan cooking of meals accordingly. However people's care plans were not always clear about their needs with regard to diet and nutrition. We discussed one person's dietary intake with staff. Staff told us the person made choices about their diet, but their plan did not mention how the person was to be encouraged to eat healthier options or look at setting goals with the person to improve their health. Another person was hoping to gain weight and this was being monitored with them in a positive way. The person told us they had put on weight and were happy about this. People were assessed for their risk of choking and one person had their meals cut up for them to reduce the risks.

People had regular access to healthcare professionals such as GPs, chiropodists, specialist teams to support people with sensory loss, opticians, specialist learning disability teams and dentists. One person with complex medical needs had recently received a review at their GP practice, involving a specialist nurse practitioner. Staff understood when emergency care was indicated for one person and we saw that they had not hesitated in calling for emergency assistance when needed. A family member told us they were confident the staff understood their relation's needs and would act quickly to obtain emergency support.

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.

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Throughout the inspection we saw evidence that people were consulted over day to day issues and choices. People were supported by staff to plan what they wanted to do each day, and then if they changed their mind this was respected and new plans made. Discussion was being held on best interest decisions regarding medicines to be given in an emergency, and work had been undertaken assessing people's capacity with regard to managing their own finances. Staff recognised that people's capacity was variable throughout the day, and could tell us how they supported people's rights to make decisions.

People can only be deprived of their liberty to 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). DoLS applications had been made for six people living in the home, but had not yet been authorised due to delays with the local authority processes.

Cedar Court comprised two semi-detached houses, in a central residential area of Paignton. The properties are close to local amenities, transport links, shops and services. One property had been converted into semi-independent living flats. Each property had their own communal rooms, with a central shared kitchen. Flats had cooking facilities and bathroom facilities that had been adapted for each individual to use. One person was busy decorating their flat with staff support during the inspection, and other people who showed us their rooms told us how they had personalised this to suit their choices. Some regular respite care was provided. For one person using the service it was very important that their personal environment remained the same from one visit to another. This person had a dedicated room for their use, so that they could ensure the environment could be managed to help reduce the person's anxiety. People did not have access to some areas without staff support. We were told this was to help keep people safe, for example by restricting access to the kitchen area.

Good

Is the service caring?

Our findings

During the inspection we observed staff working with and supporting people. Staff understood people's needs well and were able to spend time one to one following people's wishes and choices about their care. People and their relatives spoke very highly of the care and support they received. People told us the staff were of a very high standard. One said "I think they do a really good job". Relatives told us staff were "top quality" and seemed "very relaxed and know how to support people well". Another said "I hope they are being paid well enough because they really are worth every penny". Staff told us the whole staff team were enthusiastic and passionate about the people they worked with, and wanted them to develop to their full potential.

Care and support people received was based upon their wishes and choices, for example we saw one person chose the staff member they wanted that day to help them shower. Staff spent time working with people to understand what they needed and wanted and to support them with their communication. Communication from staff was clear and delivered in ways that people could understand, for example guidance or questions being broken down into smaller pieces of information that were easier to understand. One staff member told us about how one person liked to be joked with, and called by their favourite nickname. We spoke with the person and they told us they liked that name, and laughed with staff. This was also recorded in their care plan. One staff member told us about a newly admitted person "We haven't quite got to the real person yet. There is so much more to work with and develop with (person's name)." This told us staff had a positive approach to helping the person develop as far as possible, and were thoughtful about people's potential.

Staff were kind and supportive. We saw people approaching staff for comfort and physical contact. Staff were aware of appropriate physical boundaries, but also demonstrated compassion and sensitivity towards people who were exhibiting distress. One staff member told us "Nobody can teach you to care – you've either got it or you haven't". Staff celebrated people's achievements with them, and we saw evidence of this in people's rooms, with certificates of achievement or rosettes on display. A member of staff told us they had made a decision about working at the home as when they had attended for an interview they had heard a lot of laughter going on. Other staff referred to the 'investment' staff had made in developing the service and how some of the staff travelled over 60 miles a day to work at the home because they felt so positive towards the home and the people they were supporting. One told us "I get up and just look forward to coming to work".

People were treated with dignity and respect. The provider had signed up to the social care commitment as a part of their working practice. This involved staff committing to promote people's privacy, dignity, rights, health and wellbeing as part of this commitment. Staff were non-judgemental of people's behaviour. Staff knocked on people's doors and asked them if they were happy for us to see their room before entering.

Requires Improvement

Is the service responsive?

Our findings

Each person living at the care home had a plan of their care, based on an assessment of their needs. However not all information in the plans was up to date or was consistently recorded. Initial assessments were usually completed before people moved into the home. However some people had come to the home as a result of a crises or placement breakdown elsewhere which the manager told us had left little time for preparation or assessment. One person we spoke with told us they had only planned to come to live at the home in an emergency for a few weeks, but had really liked it and wanted to stay long term.

Some parts of the care plans were not up to date as they had been compiled while the person was at a previous placement rather than at Cedar Court. This meant they were not always an accurate reflection of people's current needs, wishes or goals. Other areas of the care plans did not record people's needs accurately or consistently, which led to an increased risk of them experiencing poor or inappropriate care.

Care records were maintained across two systems, to ensure information was available for quick reference wherever the person was and also in a main care file. The smaller file contained a shortened care plan of the person's needs and wishes, and review of any known risks, and would be carried by staff when they left the home. Plans were being updated at monthly meetings, and covered "What we have agreed to do" with each person to help ensure consistency of approach. Plans also included some strategies for reducing behaviour that had a negative impact on people. For example, one staff member discussed with us how they had been working with a person to try to help them manage their impulsive spending behaviours, as this quickly led to negative emotions for the person.

Daily notes were written at the time throughout the day. One file we looked at contained a daily diary written with the person and a planner to help them decide what they wanted to do each day. Care, support and staffing was then built around this. We also saw one person sitting with a staff member and planning their next days activities.

People were actively involved in developing their care plans wherever possible. Family members we spoke with confirmed they had been involved in helping with the plans where this was needed, and plans included content written by the person in some instances. Parts of the plans were available in easier to read or pictorial formats to help meet people's needs. For example one person had a planning system on their wall which helped them to make sense of what was going on that day.

The care we saw being delivered was person centred. A staff member told us "People are very much right at the centre of what we do – it's not just rhetoric here" and relatives told us they felt this was the case. A staff member told us about a person they had supported that day. They were able to tell us in fine detail about how the person liked their day structured and how they supported them to achieve this. The person's wishes were paramount in how they were supported, and if they changed their mind about what they wanted to do then staff patiently re-arranged things for them. They told us "The key with (person's name) is to listen to her" and respond to any actions early enough to stop the person experiencing rising anxiety. Some but not all files contained information on what a "good day" looked like for the person, and some plans had a goal

for people to aim towards, to help promote their independence for example.

People followed activities of their choice, both within the house and the local community. People were encouraged to be active where they wished to do so, and for some people physical exercise was a part of their own way of managing anxiety. Other people needed significant encouragement to take part in activities, or preferred more sedate ones, such as shopping or going out for coffee. Some people attended local colleges and the home's staff were keen to support people to have new experiences. One staff member described taking a person crabbing to a local harbour for example.

People were confident if they made a complaint this would be dealt with. People told us they would tell the manager or a staff member if they were unhappy or worried about something. Complaints or concerns received about the home were managed. We looked at the way in which the home had recently responded to a concern which had led to a satisfactory resolution for all parties. Policies' and procedures were in place to show how complaints and concerns should be responded to.

Requires Improvement

Is the service well-led?

Our findings

Cedar Court had previously been a care home for older people and was completing a two year progression towards becoming a home for people with learning disabilities and Autistic spectrum disorders. The directors had experience in managing services for people with these needs.

The directors and manager told us they were committed to continual improvement. However we found there was a lack of regular audit and assessment to assure the service's management of the quality of the services provided, and in some areas a lack of positive action for example with the need to develop training and support systems for staff. There were some audits such as for the environment and maintenance being carried out monthly and the manager hoped to increase both frequency and number of these with an increase in administration time available. However other audits were not being un undertaken, for example there was no specific infection control audit system in place.

Questionnaires had been sent out to families in September 2015 to gather their views about the home. We saw that where any potential improvements had been identified they had been acted upon. For example relatives had expressed concerns about the management of laundry. The manager told us the home had ensured all clothing was labelled, washed individually and each person had their own labelled laundry basket. This had helped to reduce the risks of things going missing. However, questionnaires had not yet been sent to staff or people living at the home and no analysis had been carried out of the overall responses. The manager was considering extending the questionnaires in use to include both these and other stakeholders such as GPs.

Records maintained by Cedar Court did not all clearly reflect people's needs or wishes about their care, and some were inconsistent in recording incidents or healthcare. Some records in people's files were not up to date as they had been provided through previous placements or referred to activities people enjoyed while living elsewhere. Policies and procedures that we sampled were up to date. Records were stored securely and there were arrangements for the safe disposal of records no longer needed. The service was registered with Data Protection agencies, to ensure the safe and confidential management of information.

We identified a number of concerns during this inspection which had not been addressed by the service's management.

This is a breach of Regulation 17 (1) and (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager in post told us they believed they had applied for registration with the Care Quality Commission (CQC) but this application had not been received, and therefore the manager was not registered. There had not been a registered manager in post at the organisation since 2014. The previous manager had not made formal application to de-register, but had not been working at the home since that time. This was addressed immediately after the inspection. The manager told us they would be re-submitting their application to register. They had previously been a registered manager for services of this

type.

Two of the directors were in attendance at the home on the day of the inspection, along with the manager. It was clear that there was a well-defined ethos and philosophy for the home. Staff understood their roles and how they wanted to work with people. Some staff had specifically been recruited by the directors from other homes because of their past experience and ways of working. Other staff had joined because they had seen how the home was supporting people and told us this was in line with their own values and beliefs about how people should be treated. One told us the "morals and ethos" are great here, and another told us they had worked in other homes but at Cedar Court "the people come first" which was how they wanted to work.

Staff spoke positively about the leadership of both the manager and the directors. They told us "They are here all the time. I am in awe of how much they know and how they work with people" and "we are all of the same mind-set, from the directors down". There were effective communication systems amongst the staff group, with regular meetings. Staff were supported through access to senior people at any time for advice and support through an on call system during the nights and at weekends.

The service had on-going development plans, which were flexible to meet the changing needs of people coming into the home. For example, one flat was due to be fitted out to meet the needs of the person referred to come in. A lift shaft had recently been removed to allow people more space to access the upper floors. The service development plan included works to the patio area to be carried out in Spring 2016 to make this a nicer and more useable space for people. We saw some new outdoor seating had been purchased just before the inspection, which told us work was being carried out in accordance with the plan. The directors were members of BILD (British institute of Learning Disabilities), ARC (Association for Real Change) and local manager's consortiums for sharing good practice.

Staff were clear about their roles and responsibilities. Daily duties were delegated amongst the staff team by senior staff but kept under constant review to ensure staff were working well with people and not becoming over tired. The home was very busy and active, but staff told us it was like a 'busy family home'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not being well maintained The registered persons had not established robust systems to assure the quality of the services provided or assess, monitor and mitigate risks to people's health, safety and welfare.