Care Management Group Limited

Care Management Group - 287 Dyke Road

Inspection report

287 Dyke Road
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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected Care Management Group, 287 Dyke Road on 5 January 2016. It provides accommodation and support for up to eight people. Accommodation is provided over three floors and all bedrooms were en-suite. The building is located within a residential area.

The service provides care and support to adults living with profound and multiple learning disabilities, physical disabilities and complex health needs, including epilepsy.

There were the maximum permitted eight people living at the service. We last inspected the service on 10 February 2014 where we found it to be compliant with all areas inspected.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is

Summary of findings

run. The person in charge during the inspection was the registered manager of another Care Management Group location nearby. They were appointed manager of this location following the retirement of the previous registered manager. They will be the registered manager of this location from January 2016.

The administration of a medicine was not recorded correctly and a medicine was not disposed of in line with regulations. The record for one controlled drug did not match the quantity found in the medicine cupboard. We also saw a medicine prescribed and then discontinued after one dose in July 2015. The medicine was in an unlocked box in the medicine room and we could not see where this supply of a medicine waiting for disposal was recorded. We have identified this as an area of practice that requires improvement.

People appeared happy and relaxed with staff. It was clear staff had spent considerable time with people, they knew them well and had insight into their needs. Staff knew people's personal histories and had built a rapport with them. A relative said," I can't speak highly enough of the staff; they know [my relative] and know what they are doing."

There were sufficient staff to support people. When staff were recruited, their employment history was checked, references obtained and an induction completed. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Staff were knowledgeable and trained in safeguarding and knew what action they should take if they suspected abuse was taking place. A range of specialist training was provided to ensure staff were confident to meet people's needs.

People's needs had been assessed and detailed support plans developed. They contained risk assessments for a wide range of daily living needs. These included, for example, what equipment or aids were required to be taken by staff when they escorted the person outside, in the local area or further afield. People consistently received the support they required and staff members were clear about people's individual needs. Care and support was provided with kindness and compassion. Staff members were responsive to people's changing needs.

People's health and wellbeing was continually monitored and the provider regularly liaised with healthcare professionals for advice and guidance. A healthcare professional told us, "Considering the high level of health need of the residents, staff are always approachable and very good at following care plans and reporting back any concerns. They will contact me if there are any significant health changes in residents."

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the manager understood when an application should be made and how to submit one. Where people lacked the mental capacity to make specific decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

People were provided with opportunities to take part in activities in-house and to regularly access the local and wider community. Support plans were in place to ensure people received support and healthcare that was personalised to meet their needs, wishes and aspirations. One relative said, "The care is good. The staff are very gracious about their care and treatment of people. [My relative] has complex health needs and needs a lot of specialised care. The staff have been good at watching him and giving him the care he needs."

Staff had a clear understanding of the vision and philosophy of the home and they spoke enthusiastically about working with people as part of a team. They were positive and optimistic about the management of the service. The management undertook regular quality assurance reviews to monitor standards in the home and drive improvement.

Summary of findings

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

Care Management Group 287 Dyke Road was not consistently safe.

The administration of a medicine was not correctly recorded and a medicine was not disposed of in line with regulations.

Staff were trained in how to protect people from abuse and knew what to do if they suspected it had taken place.

Staffing numbers were sufficient to ensure people received a safe level of care.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work within the care sector.

Is the service effective?

Good

Care Management Group 287 Dyke Road was effective.

Mental capacity assessments were undertaken for people if required and their freedom was not unlawfully restricted.

People were supported to stay healthy. They were supported by health care professionals for regular check-ups as needed.

Staff had undertaken essential training as well as additional training specific to the complex health needs of people.

Is the service caring?

Good

Care Management Group 287 Dyke Road was caring.

People were well cared for and were treated with dignity and respect by kind and friendly staff.

The staff knew the support needs of people well and provided individual personalised care.

Support records were safely maintained and people's information was kept confidential.

Is the service responsive?

Good

Care Management Group 287 Dyke Road was responsive.

Support plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

Summary of findings

People were supported to take part in a range of activities in the service and the community. They reflected peoples' interests and preferences.

Family members continued to play an important role and social relationships were maintained and nurtured.

Relatives and health care professionals were asked for their views about the home through questionnaires and surveys. There were systems in place to respond to comments and complaints.

Is the service well-led?

Good

Care Management Group 287 Dyke Road was well led.

Staff felt supported by management. They said they were listened to and understood what was expected of them.

Systems were in place to ensure accidents and incidents were reported and acted upon. Quality assurance was measured and monitored to enable a high standard of service delivery.

Care Management Group - 287 Dyke Road

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. The inspection checked 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 home and to provide a rating for the home under the Care Act 2014.

The inspection was carried out on 5 January 2016 and was unannounced. It was carried out by two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the home must inform us about.

During the inspection we spent time with people who lived at the service. We spent time in the lounge and dining area and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted.

People were unable to use structured language to communicate verbally with us so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four relatives of people. We gained the views of staff and spoke with the manager, two lead support workers and a support worker.

We contacted selected stakeholders including three health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided. They were happy for us to quote them in our report.

We looked at three care plans and three staff files and staff training records. We looked at records that related to how the home was managed that included quality monitoring documentation, records of medicine administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 10 February 2014 and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

People were supported to remain safe and were protected from avoidable harm. Relatives described the multiple and complex needs of their loved ones and how they felt confident that they were safe and well looked after. A health care professional commented, 'Considering the high level of health need of the residents, staff are always approachable and very good at following care plans and reporting back any concerns. They will contact me if there are any significant health changes in residents.' A member of staff said, "We help people feel safe by giving them good personal care, help them correct their posture, talk with them, make sure they have their food and encourage them to join in activities." However, we found the service was not consistently safe.

Regularly prescribed medicine was delivered on a 28 day cycle through a Monitored Dosage System (MDS) and in individual containers. They also delivered medicines used on a temporary basis and those used on an 'as required' basis. Stocks of medicines received were checked in by the responsible trained staff on duty at the time. All unwanted medicines were stored in an unlocked box in the medicine room and recorded at the time of collection for disposal by the pharmacy company responsible for delivering medicines. We saw included in these medicines was a 100ml bottle of oral morphine solution prescribed on 13 July 2015. We looked at Medicine Administration Record (MAR) charts related to its use and noted that it had been discontinued after one dose, administered on 13 July 2015. The controlled drug record book in use at the time was not available for us to look at and we did not see where this supply of a controlled drug, waiting for disposal, was recorded.

Medicines were kept securely in a locked room that was clean and ordered. Medicines that required refrigeration were kept in a fridge in the kitchen. The temperature of both the room and the fridge were monitored and recorded daily. We checked the records and saw that the temperature of the room was maintained within safe limits. On one occasion when the temperature of the fridge had noted to have risen, the fridge was adjusted and the temperature returned to safe limits. Controlled drugs in use were stored securely in a separate locked cupboard fixed to the wall.

We looked at the stocks of medicine and found that the record for one medicine did not match the quantity found in the cupboard. A member of staff told us that a further dose of the medicine had been administered on 27 December 2015. This was confirmed when we looked at the individual's epilepsy seizure diary. However, the medicine records had not been updated to reflect its use and the change in balance that remained.

We recommend the provider should take into account The Handling of Medicines in Social Care by The Royal Pharmaceutical Society of Great Britain. In addition, we recommend that they consult NICE guidelines concerning the disposal of medicines; that they should be prompt, stored in a tamper proof box in a cupboard while waiting for collection and keep a record of those waiting for disposal as well as those disposed of.

MAR records included a recent photograph of the person, a diagnosis, name of their GP, information on any allergies and where appropriate an epilepsy support plan. Some people had medicines to be used 'as required' and we saw there were clear instructions for staff to follow when considering their use. They also included details about the possible side effects of the medicines prescribed.

The MAR charts were accurately completed. Staff told us about the steps they would take if they identified a gap. Monthly medication audits were carried out to check the quality and accuracy of the medication records. We noted the outcome of the last audit in December 2015 which concluded that the staff continued to handle medication well. The manager told us that the pharmacy supplying their medicines also undertook an audit of medication management annually; the last was completed in September 2015.

Only trained staff administered medicines and the manager told us that they undertook regular e- learning training to keep them up to date with any changes. We looked at records held in the medicine files and saw that some staff had not completed any medication training in the past year. The manager told us that a further course in the 'Care of medicines' was scheduled and a course in the use of buccal midazolam was booked for the end of the month. Staff told us that they had received competency checks by the previous manager to ensure that they administered the different medicines safely. Staff we spoke with appeared

Requires improvement

Is the service safe?

confident with the procedures for handling medicines. Staff said that if they needed advice they would speak to a senior member of the team and look up their queries in the up to date reference material available in the medicine room.

We saw that regular infection prevention and control training was included in the mandatory training provided by the company. An infection control champion had been appointed. We also saw that staff were able to access personal protective clothing such as aprons and gloves when providing personal care and that people had their own slings for use with their hoists.

Staff were able to confidently describe different types of abuse and what action they would take if they suspected abuse had taken place. There were policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training. The manager showed an awareness and confidence to use the safeguarding referrals process to ensure external agencies were notified in a timely fashion. One staff member told us, "Abuse could be financial, physical or emotional. I have never seen any here but if there was a suspicion of abuse I would report it to the lead staff member on shift or the manager and they would investigate it and report it to safeguarding."

People's dignity and rights were positively managed by staff. It was evident from observation and review of documentation that staff effectively supported people by protecting their dignity and rights. People's support plans contained detailed risk assessments for a wide range of daily living needs. For example, assessments included seizures, choking and skin care. Risk assessments included clear measures to protect people, such as the use of audio epilepsy alarms fitted in bedrooms for people who required them. Risk assessments covered all aspects of daily life and included, for example, what equipment or aids were required to be taken by staff when they escorted the person outside, in the local area or further afield. Information had been reviewed and updated to reflect people's changing needs. People needed support in all aspects of their daily care. Even so, staff demonstrated they were able to offer choice and include people in the support they received.

One staff member told us, "We know people well. One person smiles to show they are happy to receive our care but bangs on their wheels or touches their face if they don't want something."

Following an accident or incident, completed forms were passed to the manager for review. We reviewed records and saw actions had been taken as a result and a clear follow up process was evident. Accident and incidents forms were sent to the provider so that learning could be shared in the other locations to try to prevent the risk form reoccurring. Staff were clear on the reporting process and that documentation was required to completed in a timely manner. The manager said, "I encourage a no blame culture where we can be open and recognise that accidents and incidents happen. That way, we can deal with them and learn from them as they arise."

Systems were in place to check the environment to ensure it was safe. We saw routine health and safety checks were undertaken that covered areas such as fire, water safety and mechanical equipment used to assist with moving people. A health and safety audit was undertaken on that covered the maintenance and servicing of equipment such as pressure relieving beds, fire systems and utilities. Staff were able to raise issues with the providers maintenance team. Larger jobs were recorded by the manager on the provider's electronic recording system. Staff told us that the Chief Executive Officer visited regularly, they told us "The CEO is approachable and takes things on board". However, one member of staff told us that the management were sometimes slow to act when things went wrong. For example, we were told that the hoist in the middle floor bathroom failed in May 2015 but was not replaced until November which meant that the staff had to use a mobile hoist for several months which they described as a, "Big inconvenience."

There were enough skilled and experienced staff to ensure the safety of people. If all people were in the house there were up to five staff on duty during the day. The manager told us that people's dependency levels were high but were reviewed and adjusted so that staffing levels reflected any identified changes. A rota identified the manager on call for night time or times when they were not in the building. All staff we spoke with told us that there were usually sufficient numbers of suitable staff to keep people safe and meet their needs. One support worker told us "We haven't always had enough staff recently but we never feel rushed

Requires improvement

Is the service safe?

when giving care as the staff team is a very tight unit. The guys come first." They told us that when someone was unwell and they needed additional support the manager arranged for another member of the team to come in or they obtained support from one of the other locations nearby also owned by the provider. One relative told us, "There are always staff there to be with [My relative]."

There were contingency plans in place in the event of an emergency. People had individual personal emergency evacuation plans (PEEP) which staff were familiar with. These reflected the staffing numbers based on the time of day or night. Information was available which included copies of PEEP's, key contact numbers and copies of people's medicine requirements. Staff were trained in first aid and resuscitation techniques.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring System check, in addition to other required documentation. The provider required two references for staff commencing work.

Good

Is the service effective?

Our findings

Staff knew people well, they had the knowledge and skills to support them. One relative told us, "I can't speak highly enough of the staff; they know [my relative] and know what they are doing."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the home was working within the principles of the MCA. The procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. There were DoLS in place and also applications pending for people. Staff were able to tell us about what restrictions were placed on people and how this may constitute a deprivation of their liberty. For example, one person was assessed for, and used, lap straps on their wheelchair in response to their uncontrolled movements.

Staff had received training on the MCA and the principles of the legislation. The MCA aimed to protect people who lack capacity, and maximise their ability to make decisions or participate in decision making. Staff had a clear understanding of people's capacity and that people were not always able to make important decisions about their care. Even though people's profound and complex needs made gaining a response difficult to achieve, we saw that staff sought people's consent before providing support. We saw within the support plans that issues surrounding consent had been considered and shared with people. Records showed that people's ability to make decisions had been assessed by the relevant professionals and information relating to consent was recorded appropriately. This process had been undertaken for a number of decisions, including the use of covert medicine. Where people were not able to make complex decisions for themselves decisions made in people's best interest were in line with legislation.

Training records confirmed that staff had completed an induction programme. The structured induction programme included an orientation during which they were introduced to the policies and procedures of the provider. Staff spent time getting to know people and read their support files and risk assessments. Time was given to shadow other staff. The manager told us they worked to ensure new staff completed the provider's induction booklet. This supported the induction process as it adapted the care certificate to reflect people's individual needs. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensured staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff completed training that the provider considered mandatory. It included such areas as safeguarding, moving and handling, fire safety, basic first aid, food hygiene and infection control. They had also completed training on the MCA and DoLS and other training relevant to the needs of the people. Staff told us that they received a range of training that ensured they were able to meet people's needs effectively. It included, for example epilepsy awareness and a positive person centred approach to support. This explored strategies and methods to increase the person's quality of life through teaching new skills and adapting the environment to promote achievement and change. This was vital for people who experienced difficulties in communicating and used behaviour and alternative communication techniques as a way to express themselves.

The manager told us that they had not yet carried out formal supervision of staff but planned to introduce monthly sessions very shortly. We saw the supervision document to be used and noted that topics to be addressed during the sessions included minutes from the previous supervision and actions, wellbeing, team working, key worker meetings, contributions to the service and support required from line manager. We saw that a summary of the discussion was to be documented along with the actions agreed. The manager told us that two lead

Good

Is the service effective?

support workers would be supervisors for some staff as they had received training in undertaking supervision as part of their lead support worker training completed in the last year.

Staff told us they were able to also speak informally with the manager if they required further support. We were told this was possible because it was a small, intimate service where everybody regularly worked with each other. Staff said supervision was useful and they were able to ask for support whenever they needed it. One member of staff said, "Supervision can be lengthy but it's so important. We talk about how we can support each service user as well as the support I need for myself. Notes are kept to check the progress I am making."

People needed specialist support with complex healthcare needs, including PEG feeding for some. This was used when people could not maintain adequate nutrition with oral intake. Nutritional assessments were in place for those people that required it that identified what food and drink they needed to keep them well. Where a need was identified, staff monitored people's weight, fluid or food intake. This was done to ensure people received sufficient nutrition and hydration. The staff saw the health gains, including improved quality of life, for people that were associated with good nutritional care. People who were on a solid food diet were supported, through various communication methods, to enable them to be consulted about their choice and preferences. Staff supported people to maintain a healthy lifestyle by providing healthy choices at mealtimes. Staff described the training on healthy eating provided by the provider and the handbook available to staff to help with this.

Everybody had a health component to their support plan. It identified the health professionals involved in their care, for example the GP, physiotherapist and specialist nurses. They contained important information about the person should there be a need to go to hospital. These were clearly written and provided health care staff with information about supporting each person. We saw that one person was being cared for in hospital following admission on health grounds. The plan was used by the hospital staff to understand the health care needs of the person. A healthcare professional commented, "The staff are extremely attentive and the service users get a very good quality of care from excellent staff."

Good

Is the service caring?

Our findings

People were supported by staff who knew them well. They were able to tell us about people's needs, their personal histories and interests. We observed staff talking and communicating with people in a caring and professional manner and in a way people could understand. One relative said, "The care is good. The staff are very gracious about their care and treatment of people. [My relative] has complex health needs and needs a lot of specialised care. The staff have been good at watching him and giving him the care he needs."

Staff spoke with people in a kind and respectful way. They were knowledgeable about people's care and were able to describe how people communicated their needs and wishes through facial expressions, gestures and sounds. Throughout the inspection people and staff were seen interacting together. They demonstrated warmth and it was clear that all staff we spoke with were genuinely fond and respectful of the people they supported. Staff told us meeting people's individual needs was one of the most rewarding elements of their role. They told us they put people first to enable them to have more opportunities in life. We observed people enjoying themselves and receiving rich stimulation from the interactions of staff. Relatives told us their loved ones were well looked after and happy living at the home. One relative said, "The care [my relative] receives at 287 Dyke Road compares very favourably with where they were before."

People had timetables of activities for each day. These were flexible and could be changed in response to how the person was feeling that day and other events in the service. Staff knew how people liked to spend their time at the service and we saw how people were supported to spend time in their bedrooms while others showed a clear preference to be in the communal areas and staff supported them in their choices. One member of staff told us, "In order to keep people happy and well cared for here you have to know them well, their cries, their facial expressions and what makes them content."

People's privacy and dignity was respected. When staff discussed people's care needs they did so in a compassionate and respectful way. People were supported to go to their bedroom whenever they needed to address aspects of personal care. This support was discreetly managed by support staff, so that people were cared for in a dignified way in front of others. For example, we observed a staff member gently suggest to a person they may like to go their bedroom to receive personal care in response to a need. We saw the communication from the member of staff was appropriately paced, clear and warm in a tone that made for a positive experience for the person. Staff made sure that doors were kept closed when they attended to people's personal support needs and we saw a privacy and dignity notice on a person's door as they received one to one personal care. Staff knocked on people's doors before they entered the room. Staff told us they maintained people's dignity by involving and talking with them about decisions to be made at the time.

Staff treated people with compassion when they became upset, staff talked with them and supported them to help identify why they were upset and helped them to resolve their distress. Just as importantly, staff could recognise and respond to signs of joy and happiness. People's likes and preferences were clearly documented throughout support plans. For example, plans identified their favourite activities and included such details as what type of music people liked. Plans identified what a good day looked like for people and how they could appear on a bad day.

People had an allocated key worker. A key worker is a person who co-ordinates all aspects of a person's care and has responsibilities for working with them to develop a relationship to help and support them in their day to day lives. Key workers told us it was essential there was a bond and mutual respect between the person and their key worker to ensure people received the best possible care. Staff told us keyworking responsibilities included supporting people to buy toiletries and other items essential for their person care needs, spending additional one-to-one time with them and reviewing and updating monthly support plans.

The people living at the service came from a diverse range of cultural and ethnic backgrounds. This was recognised and embraced by the provider and staff. One person attended church on a regular basis and had the gospel choir attend the service to sing. We were told that one person received support to phone his father every day. During the call he was read the Koran. People's bedrooms reflected their culture and heritage and were individually decorated and furnished with people's own items including their own family and personal pictures.

Good

Is the service caring?

People were supported to make choices and to be as independent as possible. A member of staff described how they took their cues from people they supported. For example, they described how helped people to choose their own clothes to wear each day. They told us how they provided gentle encouragement to a person who liked to put their own sweater on.

The management and staff followed the principles of privacy in relation to maintaining and storing records.

There were arrangements in place to store people's support records, which included confidential information and medical histories. There were policies and procedures to protect people's confidentiality. Support records were stored securely on either the provider's computer system or in support files. Staff had a good understanding of privacy and confidentiality and had received training.

Good

Is the service responsive?

Our findings

Relative's said they felt fully involved in the care and support of their family member. They told us that they were updated with any changes or issues that affected their loved ones support. One relative said, "The keyworker sends me an update regularly but I ring every week and get an update that way as well. If there's anything I need to know about they phone me to tell me. The communication has been good."

People's support plans clearly identified their needs and reflected their individual preferences. Support plans focussed on the individual. Information such as their past life history, how they expressed preferences, and how they communicated their everyday support needs were in the plans. Support plans were amended as required and were signed to say they had been reviewed. The manager recognised the need to continually review people's plans. The plans were working documents that were amended as people's needs changed and were updated when changes had been made.

Documents in support plans advised staff how people liked to receive care. Plans demonstrated assessment of people's individual needs and clearly identified how these could be met. Areas included their independence, nutrition, personal hygiene and communication. These gave detailed examples of a person's personal preferences such as favourite music and for those on solid foods, dishes they particularly liked or disliked. Pen portraits gave a quick reference that contained all pertinent information related to the person. These were located at the front of the file, and offered concise details of importance. One staff member told us, "We know when people are distressed and how to respond. One person rocks and bites their thumb so we calm them down by putting their favourite film on their IPad for them to watch or let them listen to Whitney Houston."

Support plans contained sections that set out information for staff when they cared for people who faced challenges to verbal communication. Likes and dislikes identified where people were able to makes choices and retain control in aspects of their daily routines such as clothing and meals. Care plans were regularly reviewed, followed by a more comprehensive review involving family and/or advocates, social workers and the person's key worker.

Staff had a good understanding of people's individual needs and said they were given time to ensure documentation, including daily notes were up-to-date. Support staff were familiar with people's day and night care needs and their routines they had developed around their day. We saw daily care records provided clear informative descriptors of people's activities, demeanour and behaviours. Staff told us these were useful to review if they had been off duty for a few days.

Activities were person centred and recorded in plans to ensure consistency. Some people benefitted from picture timetables to show what they had planned each day. We saw photographs of people taking part in various activities at home and out and about in the community. Some people attended the providers own resource centre directly located behind the location. The duration of the support provided was flexible and varied from a couple of hours a week to more intensive support that people went to more regularly. People were provided with structured and spontaneous opportunities through in-house activities or in the local area. A member of staff said, "We help people feel safe by giving them good personal care, help them sit properly, talk with them, make sure they have their food and encourage them to join in activities." We observed sensory activities around the service, including in peoples bedrooms on a one to one level and as a group in the lounge. These sensory focused activities helped people to feel calm and relaxed or to be stimulated and alert, depending on the stimulation offered within environment. Sessions were aimed at maximising the participation of the person.

We observed staff had a handover between shifts. Individual updates on people featured prominently. It provided staff with a clear summary of the support provided to each person and enabled them to allocate duties for that day. Staff had the time and opportunity to ask each other questions and clarify their understanding on issues relating to people and planning the shift.

Key worker meetings offered an opportunity for interaction on a one-to-one basis with each person. They allowed the key member of staff to learn and share the preferences and needs of the individual and helped to ensure the package of support was responsive to their needs. This information

Good

Is the service responsive?

was shared with the team, through updated plans, handovers and team meetings. We found documentation related to this in the team meeting minutes and observed this during handover.

Reviews were held annually or in response to changing needs. Relatives were involved, where appropriate, in the way the service responded to the needs of the people. A relative described their experience of the review process, "[My relative] moved in just over a year ago. It was phased in over weeks and months so that they became used to it. There was a formal six month review but just as importantly, I have been kept well informed at every stage." A picture emerged from feedback and observation, of a service that aimed to facilitate support that catered to the individual complex needs of people.

There was a complaints procedure and information on how to make a complaint was displayed. Relatives told us they were aware of how to make a complaint. We reviewed the complaints log and asked the manager to explain what they would do should a complaint arise. They were clear that they would make sure their management of the concern was entirely transparent, that included a full investigation, with the complainant being told of the outcome. People's relatives were confident that the service would correctly deal with a complaint. One relative stated, "My [relative] receives great care and staff take note of what I like and don't like. If I have a query I can raise it with staff and the manager has rung me back. They have a new manager and I have not yet had any contact but expect that to happen but it's not a complaint as such."

Satisfaction questionnaire surveys were undertaken on an annual basis. Relatives were surveyed and their feedback was seen to be positive. The information that was captured was collated and the results were shared. A relative told us, "I have had two questionnaires through. It gave me the chance to give feedback. They asked similar questions to what you're asking."

Good

Is the service well-led?

Our findings

There was a manager in place. They worked there between two or three days a week. They were dividing their time between this service and another within the provider's local group of services. A date was set for the manager to move full time to the service and staff were looking forward to that development. One member of staff said, "We would like a manager to be one of us, who doesn't mind getting their hands dirty and who will jump in and help if there is a need." When they were not present a team leader was at the service and led the shift. Staff demonstrated a clear understanding of their roles and the lines of accountability. One member of told us, "The manager is nice. I can go to her and talk with her." Staff told us there was a senior member of staff available at during the week. All staff were aware of the on call system in place when a senior member of staff was required out of hours. One staff member said, "You can speak to a manager if you need one."

The provider had clear published vision and values; these ran through the policies and procedures for their services. Staff discussed procedures, encompassing values, at team meetings. Staff were clear on the vision and philosophy that underpinned the service. The manager was clear that the provider's core value statement 'Every moment has potential' was taken to heart by the team. One staff member told us their saw their role as, "Helping to make sure people have the best, most fulfilled life possible." One member of staff described the strength of the service as they saw it, "The best thing about this home are the service users and the close teamwork." Another said, "A good thing here is the atmosphere. It has a family feeling. We know the residents well and they know us."

Staff meetings were held monthly. Staff who were unable to attend were provided with minutes of the meetings. These meetings provided an opportunity for staff to raise and discuss issues and for management to remind colleagues about key operational issues. Staff told us they found these meetings useful and provided an opportunity to share ideas and provide each other with updates on individual people. One staff member said, "Staff meetings are useful. We discuss all our service users, staff issues and any planned changes in the unit."

Robust quality assurance systems were in place to monitor the running of CMG 287 Dyke Road and the effectiveness of systems in place. Audits were undertaken for a wide range of areas, these included medicines, support plans and health and safety. Quality audits were also undertaken by a visiting regional director. These were detailed documents and provided the manager with an overall score and clear action plan for each area looked at. For example, the last audit from November 2015 found that some keyworker reports required more detail about the opportunities taken for activities and for them to be shared with the family of people. This was fed back to the manager and there was a section for the manager or responsible person to indicate what actions they had taken in response to the prompt. The manager said, "It is incredibly useful to have another person look at how the service runs."

The manager told us they felt well supported by their line manager. They thought that communication was effective, aided by their proximity to the regional directors office next door to the building. During our inspection we heard the manager liaise with the provider's administration head office by telephone. The manager said, "I get help and advice from the provider when I need it." They described the training and support events they were part of. For example, the manager attended the local authority learning disability forum. They were a manual handling trainer for the provider and a member of the manual handling steering committee to consider and lead on issues in this important area of care and support.

The manager identified in their PIR that a focus for the service was to improve the use of inclusive technology to enable staff to further meet people's social and emotional needs. During the inspection they identified methods they used to achieve this, including the introduction of communication cards and individual objects of reference on, for example, people's wheelchairs. The manager recognised that they need to take the team with them on this journey. They said, "The service users have such complex needs that it is good we have such experienced staff. But an important aspect of the job is talking and learning, in supervisions and in team meetings and learning from each other."

The manager was aware of the relatively new statutory Duty of Candour which aims to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The manager was able to describe unintentional and unexpected scenarios that may lead to a person

Good

Is the service well-led?

experiencing harm and was confident about the steps to be taken, including producing a written notification. They were able to demonstrate the steps they would take including providing support, truthful information and an apology if things had gone wrong.