Connifers Care Limited

Cedar House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Cedar House is registered to provide two regulated activities; accommodation for persons who require nursing or personal care and personal care. The service has a care home and also provides a domiciliary care service to people living in supported living schemes.

The care home was last inspected in December 2015; however, this was the first comprehensive inspection of the domiciliary care service.

We have written our report under the headings Care Home and Domiciliary Care Service to ensure that our specific findings for both services are clear.

Care Home

This inspection took place on 22 and 23 February 2018 and was unannounced.

Cedar House is a residential care home for six people with enduring mental health conditions, learning disabilities and complex healthcare needs. On the day of our inspection there were five people using the service.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

People told us that they felt safe living at Cedar House. Care staff demonstrated a clear understanding of what it meant to protect people and the steps they would take to keep people safe and free from harm.

Risk assessments identified people's individual risks and provided detailed guidance for care staff on how to mitigate or minimise risk in order to keep people safe.

The provider followed robust recruitment processes to ensure that only care staff assessed as safe to work with vulnerable people were employed.

People received their medicines safely, on time and as prescribed. The provider had systems in place to ensure the safe management of medicines.

Accidents and incidents were recorded, monitored and analysed in order to support further learning and improvement.

Care staff received regular support and development through training supervision and annual appraisals in order to effectively carry out their role.

At the last inspection we found that some people using the service may have had their liberty restricted without the appropriate authorisations in place. At this inspection we found that this had been addressed. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed kind and caring interactions between people and care staff, where people had built positive relationships with the care staff that supported them.

People and relatives knew who to speak with if they had a complaint or concern and were confident that their concerns would be dealt with appropriately.

Care plans were detailed and person centred and provided clear information about the person, their likes, dislikes, choices and preferences on how they wished to be supported.

Appropriate management oversight systems in place ensured that there was continuous monitoring of the care and support people received. Where issues or gaps were identified processes in place supported learning and improvement to allow the delivery of high quality care.

Further information is in the detailed findings below

Domiciliary Care Service

This inspection took place on 22 and 23 February 2018 and was unannounced.

This is the first comprehensive inspection of this service. Cedar House provides the regulated activity of personal care. This service provides care and support to people living in a number of 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. Not everyone using the service receives the regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service aims to support people with enduring mental health conditions, learning disabilities and complex healthcare needs. At the time of this inspection there were three people receiving personal care.

Cedar House currently provides the regulated activity within two supported living schemes. One scheme accommodated two people and the second scheme accommodated six people.

People using the service lived in a single 'house of multi-occupation' shared by people across North London. Houses of multiple occupation are properties where at least two people in more than one household share toilet, bathroom or kitchen facilities.

There was a registered manager in place at the time of this inspection. However, a second manager had submitted an application to the CQC to become the registered manager of the regulated activity 'personal care' so that the registered manager overall would then be the registered manager solely of the regulated

activity of 'Accommodation for persons who require nursing or personal care'. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives told us that they and their relative felt safe with the care and support that they received.

A safeguarding policy was available and accessible which related to keeping people safe from abuse. Care staff understood the key principles of safeguarding people and the actions they would take if people were subject to or at the risk of harm.

Care plans contained detailed risk assessments which identified and assessed people's individual risks and provided risk management strategies in order to ensure that care staff were provided with sufficient information so as to keep people safe and free from harm.

We observed appropriate staffing levels that met the needs of people appropriately. The provider had robust recruitment processes in place which checked and assessed potential care staff identity, conduct in previous employment and carried out a criminal record check.

Medicines were managed, recorded and administered safely. Appropriate arrangements were in place which ensured that people received their medicines safely and as prescribed.

All accidents and incidents were recorded and monitored. After each accident or incident a post incident meeting was held to analyse the information in order to learn and improve the way in which each incident was handled and managed.

A regular programme of training and development was in place for each care staff in order to ensure that each care staff had the appropriate skills to provide effective care and support. In addition care staff received regular supervision and annual appraisals in order to support them in their role.

People's needs and choices were comprehensively assessed before they were offered a place at the supported living scheme. People's likes, dislikes, choices and preferences were taken into account so that an appropriate package of care could be developed and delivered.

People were appropriately supported with their nutritional and hydration needs. People were supported to plan their weekly menus which incorporated their likes and dislikes as well as ensuring a health and balanced diet was maintained.

People were supported to maintain good health and had access to a variety of healthcare services where appropriate.

The service understood the core principles of the Mental Capacity Act 2005 and effectively applied this where required in order to support people effectively and in line with current legislation. Care staff were able to demonstrate the ways in which they obtained consent from people. They understood the need to respect a person's choice and decision where they had the capacity to do so.

We observed caring, kind and respectful interactions between people and care staff. Care staff knew the

people they supported very well and we observed them to be responsive to people in a way which took into account the individual's personality, behaviour and health needs.

We observed people to be involved in how they wanted to receive their care and support. People were able to choose the activities that they found interesting and wished to participate in ensuring autonomy and independence where possible.

People and relatives knew the managers and care staff that delivered care and support and were happy to raise any concerns and issues with them. The service to date had not received any complaints.

The provider had a number of processes in place which enabled the service to monitor and evaluate the quality of care provision in order to continuously learn and improve. The service regularly requested feedback from people who used the service.

Care staff told us and records confirmed that the provider held regular staff meetings which enabled effective communication exchange and encouraged staff to discuss issues and areas for improvement.

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

Care Home
The service remains Good.

Domiciliary Care Service
The service was safe. Safeguarding policies in place were clearly understood by care staff and care staff knew what to do to address suspected abuse.

Risk assessments in place provided detailed information and guidance to care staff on how to mitigate or reduce risks in order to keep people safe and free from harm.

People received their medicines safely and as prescribed. Robust systems and processes in place supported the safe management of medicines.

Sufficient numbers of staff were observed throughout the inspection. Safe recruitment processes had been followed in order to ensure appropriate recruitment of staff.

Accidents and incidents were recorded, monitored and analysed to support further learning and improvement to service provision.

Is the service effective?

Good

Care Home
The service was effective. Where people using the service may have had their liberty restricted, appropriate authorisations were in place in order to ensure people were supported in line with current legislation.

Domiciliary Care Service
The service was effective. People's care and support needs were comprehensively assessed so that a package of care was developed which met people's identified needs effectively.

Care staff received regular support and guidance through training, supervision and annual appraisals.

Care staff understood the key principles of the MCA 2005 and

were able to explain how the principles were applied when delivering care and support.

People were supported with their nutritional and hydration needs in a way which maintained a healthy and balanced diet.

People were supported with their healthcare needs where required. Referrals were made to appropriate healthcare professionals where a specific need was identified.

Is the service caring?

Good

Care Home
The service remains Good.

Domiciliary Care Service
The service was caring. We observed kind and caring interactions between people and care staff. We observed that people had established positive relationships with care staff that were based on mutual trust and respect.

People were always involved in every aspect of their care, support and treatment. People's choice, likes, dislikes and preferences had been recorded and was always integral to the delivery of care.

People and relatives told us that their privacy and dignity was always respected and that they were supported to be independent as far as practicably possible.

Is the service responsive?

Good

Care Home
The service remains Good.

Domiciliary Care Service
The service was responsive. Care plans were detailed and person centred and provided clear information and guidance which was responsive to the person's needs.

People and relatives confirmed that they knew who to speak with if they had a complaint or concern and were confident that any concerns would be dealt with promptly and appropriately.

Is the service well-led?

Good

Care Home
The service remains Good.

Domiciliary Care Service
The service was well-led. People and relatives knew the management team well and told us that they were always approachable.

A number of systems and processes were in place to allow the service to monitor and oversee the quality of care being delivered. This allowed for learning, development and improvement to take place.

People, relatives and various other stakeholders were asked to give feedback, comments, ideas and suggestions on the quality of care and where improvements could be made.

The service worked in partnership with a variety of external agencies including day centres, leisure centres and advocacy services so that people had access to a variety of wider social care services.

Cedar House

Detailed findings

Background to this inspection

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

Cedar House is registered to provide two regulated activities; accommodation for persons who require nursing or personal care and personal care. The service has a care home and also provides a domiciliary care service to people living in supported living schemes.

The inspection for both the care home and domiciliary care service took place on 22 and 23 February 2018 and was unannounced.

Inspection site visit activity started on 22 February 2018 and ended on 23 February 2018. It included visiting the care home, the registered office for the domiciliary care service and one supported living scheme.

The inspection was carried out by two adult social care inspectors and one expert by experience who made telephone calls to relatives on the second day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information that we had received about the service from health and social care professionals, notifications that we had received as well as the provider information return (PIR) that the provider had sent to the Care Quality Commission (CQC). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection at the care home, we spoke with the registered manager and one care staff. In addition we spoke with the provider. We also observed interactions between people and care staff. We reviewed a range of records about people's care and how the service was managed. At the care home these included care plans for five people's care plans, four care staff files, five people's medicine administration records, staff training records, quality surveys and a range of policies and procedures. After the inspection

we conducted telephone interviews with a further three care staff.

During the inspection at the domiciliary care service we spoke with the area manager, one scheme manager and one care staff. We reviewed a range of records including two care plans, 10 care staff files, two people's medicine administration records, staff training records, quality surveys and a range of policies and procedures. After the inspection we conducted telephone interviews with a second scheme manager and a further three care staff.

Good

Is the service safe?

Our findings

Care Home

People and relatives told us that they felt safe with the care and support that they received. One person told us, "Yes, I feel safe." One relative told us, "Safety is adequate here. Staff continuously monitor my [relative]."

The provider's safeguarding policy clearly defined the different types of abuse and the actions to be taken where abuse was suspected. Care staff demonstrated a good level of understanding in this area and were able to clearly describe the steps they would take to protect people from abuse. Care staff also knew how to 'whistle blow' and the external agencies that could be contacted to escalate their concerns. This included the local authority, CQC and the police.

Risk assessments in place identified people's individual risks associated with their health and social care needs. Clear guidance and management plans gave care staff information on how to support the person to reduce or mitigate the risk in order to keep them safe from harm. Examples of risks that had been assessed included, self-neglect, sexually inappropriate behaviour, addiction and relapse in mental health. Risk assessments had been reviewed periodically since the last inspection or as and when required if significant changes had been noted.

We observed sufficient numbers of staff supporting and meeting the needs of people living at the home. Where required people were supported on a one to one basis especially when accessing community services for social activities.

The provider had robust systems in place to ensure the safe recruitment of staff. Pre-employment checks including a criminal records check, conduct in previous employment and identity verification checks had been completed. The provider ensured that all staff recruited to work at the service had been assessed as safe to work with vulnerable people.

Safe medicine management and administration processes in place meant that people were administered their medicines safely, on time and as prescribed. All records relating to medicine administration and management had been completed appropriately with no gaps or errors in recording. People who had been prescribed high risk medicines which require monitoring and review were supported with this when required. Details of how the person was to be supported with the particular medicine and its associated risks were clearly documented. Where people had been prescribed 'as and when required' (PRN) medicines, a PRN protocol was in place which detailed the medicine, why it had been prescribed and when they should be administered. The registered manager completed daily and weekly medicine checks to ensure that people were being administered their medicines safely and appropriately.

Care staff told us and records confirmed that they had received medicines training. Observations of care staff were also completed as part of their induction process in order to assess their competency. However, the competency assessments were not reviewed thereafter to ensure care staff were regularly assessed as

competent in administering medicines. We highlighted this to the registered manager and provider who confirmed that this would be something they would implement going forward.

All accidents and incident were recorded, monitored and analysed after each event. A post-incident meeting held after each incident, gave all care staff involved an opportunity to review, reflect and analyse all information leading up to the incident and the actions taken so that areas for further learning and improving could be identified and applied going forward.

Care staff had access to a variety of personal protective equipment so as to protect people from cross infection and contamination. This included gloves and aprons. We checked all food storage areas including the fridge and freezer and found that these were clean. All opened food items had been labelled with the date of opening clearly recorded. This ensured that people had access to food which was safe to consume.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety and water safety were undertaken. Personal Emergency Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency.

Domiciliary Care Service

People living at the home were unable to understand and respond to some of the questions that we asked them about whether they felt safe living at the home and with the care staff that supported them. This was due to communication difficulties they encountered due to their disabilities. However, during the inspection we observed that people seemed to be ease with the care staff that supported them and they were able to express themselves without fear to which care staff responded appropriately to ensure the person felt safe and re-assured within their own surroundings.

Relatives confirmed that their relative was safe and that care staff ensured the person's safety at all times. One relative told us, "My relative sleeps few hours in the night. So if he wants something in the night, the staff are always at his disposal and provide anything he might need."

The scheme manager and all care staff demonstrated a good level understanding of how to safeguard people from abuse and the steps they would take where abuse was suspected. Safeguarding policies and procedures in place supported staff in this area. Care staff told us, "Safeguarding is about safeguarding my service user to protect them from harm or abuse. I will report it definitely" and "We are all there as care workers to protect people who are unable to protect themselves. We always report to the manager." Care staff knew of the term 'whistleblowing' and clearly stated a number of external agencies that could be contacted if their concerns needed to be escalated including the local authority and the CQC.

People's care plans included detailed information about risks associated with their health and social care needs. This included risks associated with self-neglect, violent and aggressive behaviour, choking, compliance with medicines and absconding. A risk management plan was in place for each risk and detailed the actual risk, the warning or trigger signs of the potential risk and clear directions for care staff on how to manage the risk. Risk assessments were reviewed every month or sooner if significant changes were noted.

Cedar House provides the regulated activity of personal care within supported living schemes. One care staff member was always available 24 hours per day for access by all tenants living at the scheme when required. Where people had been assessed as requiring one to one support, the provider had put this in place. Therefore, there were no concerns relating to late or missed visits as a care staff member was always

available to support people when required.

The provider had robust process in place to ensure that people received their medicines safely and as prescribed. Appropriately completed documentation was available which confirmed that people were supported with their medicines and received them according to their needs and requirements. This included medicine profiles, medicine administration records, 'as required' medicine protocols, and risk assessments especially where people had been prescribed high risk medicines. 'As required' medicines are medicines that are prescribed to people and given when necessary.

The provider completed monthly medicine audits to ensure that any issues or discrepancies were identified and rectified immediately. All staff received training on medicine administration and competencies were assessed through observation by a senior member of staff as part of the induction programme. However, the service did not continue to observe care staff administer medicines to confirm competency in this area. This was highlighted to the scheme and area manager who confirmed that this would be something they would implement going forward.

All accidents and incidents were clearly documented with details of the incident and the actions taken. Following each incident the care staff team held a post incident meeting to discuss the event, the triggers leading to the incident and the effectiveness of the actions taken to see whether further learning or improvements could be implemented. One scheme manager told us, "Post incident meetings are helpful for all staff to get together. We discuss ideas and find solutions about what went wrong and how we could have dealt with the situation better."

The provider ensured that robust recruitment processes were always adhered to, to ensure that only care staff assessed as safe to work with vulnerable people, were employed. Records confirmed that a number of pre-employment checks were carried out which included criminal record checks, references confirming care staff conduct in previous employment, eligibility to work in the United Kingdom where appropriate and identification checks.

The service ensured that staff understood infection control and how to protect people from infection. Staff had been trained in infection control and had access to a variety of personal protective equipment including gloves, aprons and shoe covers.

Good

Is the service effective?

Our findings

Care Home

People were unable to comment on whether they felt staff were adequately trained to support them due to their disability. Relatives, however, did confirm that they felt staff were appropriately skilled and trained to carry out their role. One relative told us, "The staff are efficient with great dignity and respect."

Care staff told us and records confirmed that all staff had received an induction and all relevant training prior to starting their employment. The service then continued to provide regular on-going training to ensure that care staff were supported in delivering effective care at all times.

Supervisions and annual appraisals were also used as ways in which to support care staff in their role. Care staff told us that they were appropriately supported and were always encouraged to pursue further development within their career. One care staff told us, "I have no problem with training. I ask for training they gave it to me. I feel supported. Any time I ask they will show me."

Records confirmed that people's needs where comprehensively assessed prior to admission to Cedar House. The assessment covered every aspect of the person's health, care and social needs and also obtained detail about the person's personal life. This enabled the service to develop a detailed care plan which took into account people's needs, choices and preferences on how they wished to be supported. The pre admission assessment also allowed the service to determine whether they would be able to effectively meet the needs of the person.

People were supported to eat and drink at all times and where people had been assessed as requiring specialist assistance with their meal this had been recorded appropriately with clear directives for all care staff on how the person was to be supported. People planned their menus with the support of care staff on a weekly basis and two options of a meal choice were always available. People's likes and dislikes along with any cultural or religious requirements in relation to food and drink had been clearly documented.

Daily handover and observation records were used as methods for all care staff to communicate within the team significant and relevant information about people. This ensured people were supported effectively and consistently at all times and that care staff were always aware of all pertinent information about the person. We also saw records confirming that the service supported people to access a variety of external healthcare and social services where a need had been identified.

Details of people's involvement with a variety of healthcare professionals including GP's, opticians, dentists, psychiatrists and chiropodists had been clearly documented in the person's care plan. Records included details of the appointment and any follow up actions that were required. The service ensured that staffing levels were adjusted to ensure that where people required assistance to attend appointments this was available.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards. At the last inspection we found that some people using the service may have had their liberty restricted without the appropriate authorisations in place. At this inspection we found that this had been addressed. Senior managers as well as staff members demonstrated a good level of understanding in relation to the MCA and its principles and how this may affect a person that they supported. One care staff told us, "We cannot deprive them of their liberties as it may be a type of abuse."

Care plans clearly documented people's capacity and the decisions they were able to make. Where people lacked capacity to make more complex decisions this was clearly documented with details of how the service and where appropriate family members were to support the person with decisions that needed to be made. People had where possible signed their care plans, however, in some cases people who had signed their care plan had been assessed as lacking capacity. We discussed the appropriateness of this and whether people who lacked capacity had an understanding of what they were signing with the registered manager and provider who agreed that they would consider this for future care planning. Relatives had signed care plans where appropriate confirming their involvement with the care planning process.

Domiciliary Care Service

The service carried out a comprehensive pre-service assessment to ensure that they were able to meet the needs of the person as well as deliver care and support in line with the person's choices, preferences and wishes. The pre-service assessment included detailed information on the person's health needs, communication, associated risks and placement suitability. Where appropriate the person, relatives and all involved health care professionals had been involved in the process. Following the assessment a care plan had been compiled which detailed all known information about the person, their needs and any identified risks associated with their health and care support needs. All care plans and related documents were reviewed on a monthly basis or sooner if people's identified needs had changed.

Care staff told us and records confirmed that each care staff received an induction before they started work which included training in a variety of topics as well as a shadowing period where they were allocated to work with an experienced care staff until they felt confident to work independently. Training was refreshed periodically and care staff were encouraged to access advanced training to support them with their professional development. Comments from managers and care staff included, "I have learnt a lot from this company. I have received training and gained experience", "There is a lot of opportunities this company give us. In four years I have had the opportunity to do my level two and three in care" and "My training is still on-going. My induction is over a six month period." Relatives told us that they believed care staff were appropriately trained to carry out their role.

Care staff were also supported regularly through supervisions and annual appraisals. Care staff confirmed that they found these support systems a positive experience where they were given the opportunity to discuss any concerns, issues and personal development that they had in order to ensure that they were delivering the best possible care to people. Comments from care staff included, "Supervisions are weekly at the moment. They are helpful because I am new" and "We talk about things that I haven't done right or done well or where I need help."

The service supported people in supported living schemes and so where appropriate people were supported with their nutritional and hydration needs where this was an identified need. Menus were

planned on a weekly basis with the person taking the lead in deciding what they wanted to eat and drink. However, people were able to change their minds on the day and choose an alternative which was always acted upon. Following the planning meeting people were accompanied to go shopping in order to purchase the required food and ingredient items. People's likes, dislikes and preferences regarding their meals had been clearly documented within their care plan. Where people required specialist support and assistance due to specific health care needs this was clearly documented with guidance to staff on how the person was to be supported effectively.

Daily handover records and observation notes were completed by the care staff team to ensure that information about people was clearly communicated across the service so that people received consistent care and that arising issues or matters were dealt with effectively. We also saw records detailing communication between the service and a variety of external health care professionals where the service had identified specific needs or issues. For example, the service had recently made a referral to the local authority learning disabilities team for someone to receive a positive behavioural support assessment.

People were supported to access a variety of health care services which included the community nurse, GP, speech and language therapists, opticians and a variety of hospital services. Each visit or appointment had been recorded with details of the outcome and actions to be taken. The service ensured that one to one support was available to people in order for them to effectively access any such service.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. The service was currently in the process of discussing and applying for 'judicial DoLS' in partnership with people's allocated care co-ordinators or social workers.

Care staff demonstrated good knowledge of the MCA and of each person's mental capacity and ability to cope with decisions. For example staff gently guided people with mental capacity who were likely to make unwise decisions but respected their right to do this and did not intervene inappropriately. Care staff were able to give clear examples of how the MCA impacted on how they supported people on a day to day basis. One care staff told us, "I can't assume that people don't have capacity. I always assume capacity. It's about protecting people and acting in their best interest." A second care staff told us, "Most of the people I work with have capacity but I work with people in a way that I am not making decisions for them. We explain things to people and inform them of the associated risks."

People had signed their care plans confirming that they had consented to their care and support package. However, in some cases people who had signed their care plan had been assessed as lacking capacity. We discussed the appropriateness of this and whether people who lacked capacity had an understanding of what they were signing with the registered manager and provider who agreed that they would consider this for future care planning. Relatives had signed care plans where appropriate confirming their involvement with the care planning process.

Good

Is the service caring?

Our findings

Care Home

People told us that care staff were caring and nice. One person said, "Yeah staff are okay and nice." All the relatives had very good words about the staff who seemed to be caring and respectful.

We observed caring and respectful interactions between people and care staff. We were told about one person who was unable to communicate and would not engage with care staff. Since they had been at Cedar House, the person had progressed and was now able to express themselves clearly and had built positive relationships with the care staff. The person's relative told us, "When my relative arrived at Cedar House she was not talking. Now she initiates a conversation and she can hold it for some time. Before she couldn't."

We observed that people were involved in every aspect of their care and support where possible and people were enabled to make their own day to day choices and decisions. Care staff knew the people they supported well and were very aware of their likes, dislikes, preferences and choices as well as their personalities and behavioural traits. With this knowledge care staff knew how to support people in a way which took into account their mental health needs and disabilities and supported them to maintain positive well-being.

Relatives confirmed that their relative was always treated with dignity and respect. We also observed care staff speaking with people in a respectful manner and ensuring that their privacy and dignity was maintained at all times. Care staff were able to give us clear examples of how they maintained people's privacy and dignity. One care staff told us, "When you are speaking to the person you need to do so politely and with respect, maintain confidentiality. We cannot talk about people in public."

People were encouraged to maintain their independence wherever possible. We observed people being encouraged to be involved with daily living activities such as cleaning, cooking meals and shopping. Care staff understood the importance of promoting people's independence and told us, "It's about getting involved in whatever the person wants to do and then guiding them" and "It's about helping them to do things themselves. One person likes to cook and we keep a watch."

Care plans were reflective of people's cultural, religious and personal diversity and staff were clearly aware of people's individual needs and how these were to be met. We asked staff about supporting people who may identify themselves as lesbian, gay, bi-sexual and transgender (LGBT). Care staff responses included, "You have to respect people. Your sexuality does not make you different" and "My client is the most important person to me."

Domiciliary Care Service

One person told us that they were "happy" living at the service. We observed them to have developed very

caring relationships with particular care staff which was based on mutual trust and respect. Relatives told us that their relative was happy and that they received a good service from good care staff. One relative told us, "My relative has a young woman as her carer. Very fond, great respect, wonderful woman. She goes beyond." A second relative commented, "He [Relative] is well groomed, he always seems quite happy. It's a good place. Excellent care. No concern on my relatives wellbeing."

During the inspection we observed the relationship that had been established between one person and the care staff supporting them. This relationship had been built on trust, mutual respect and care. People were seen to be involved in every aspect of their daily living and were encouraged to make their own choices and decisions. One relative told us, "The staff know my mother very well. They involve her in everything. What colour the lampshade she wanted or if she wanted the TV on the wall." Care staff knew the people they supported well and understood their personalities and behaviours which enabled them to support them according to their specific needs.

People were also encouraged to be involved in every aspect of their care and support through key worker and one to one sessions which were held on a monthly basis. People and their allocated key worker, as part of the key worker process would review the care plan and discuss any changes as well as future plans or activities that they wished to participate in over the forthcoming month.

People living at the schemes were supported by care staff in a way which promoted their independence. People held their own tenancy agreements and were responsible for maintaining certain aspects of their own care and housekeeping where possible. People were supported and empowered to undertake a variety of daily living tasks which included cleaning, cooking and shopping for the own food.

We observed various examples of care staff respecting people's privacy and dignity which including knocking on their doors before entering, ensuring their dignity was maintained at all times and ensuring confidentiality. One care staff told us, "I always knock on their door and ask them if they need assistance." A second care staff said, "In the house I make sure when supporting the person with personal care I close the door and I always speak to them in a way that they can understand me."

Care staff understood the importance of promoting people's independence and empowering them to live an independent life as far as practicable possible. One care staff told us, "I let [person] do her own things. Even if she does it wrong I will let her do. She is very independent." A second care staff said, "I support them and let them choose what they want to do. I help them to promote their independence and I help them to make their own decisions."

Care plans recorded people's cultural, religious and personal diversity and were supported to follow and practise their beliefs where the person had expressed their wishes in this area. One person was supported to attend his preferred place of worship on a regular basis. Care staff the understood the importance of supporting people with their beliefs and diversity. Comments from care staff included, "I am here to support people, not to judge them" and "It would not make a difference to me if someone was gay or a lesbian. I am there to care for the person and my job is to deliver what is needed."

Good

Is the service responsive?

Our findings

Care Home

Care plans were person centred and detailed and listed comprehensive information about the person including their likes, dislikes, preferences, choices on how they wished to be supported. This ensured that people received care and support that was responsive to their needs. Care plans were reviewed regularly and always involved the person as well as their relative or any involved health care professionals. One relative told us, "I don't have formal review meetings but I always chat with them now and then. Everything is documented. All the procedures are in place."

Each person was allocated a named keyworker who was responsible for reviewing the persons care plan and risk assessments as well as reviewing their set goals and targets in relation to their health and social care needs. The key worker met with the person on a monthly basis to review their care and support needs. One person's care plan had recorded, "My allocated key worker, to build upon a professional therapeutic relationship with me, based upon trust, empathy and mutual respect. To encourage me to participate in regular one to one sessions with my key worker to enable me to ventilate my feelings in a safe, non-threatening environment."

People were supported to attend and participate in a variety of activities which also included attending a day centre which was also owned and managed by the provider. An activity folder displayed details of the activities organised with photographs of people participating. Activities included birthday parties, outings, sports days, football coaching, music therapy and swimming. Comments from people included, "I do go swimming sometimes. Been going to the pavilion [day service]. Oh and I talk to people" and "They do go with me if I want to go shopping."

Relatives were very positive about how people were supported and encouraged to participate in a variety of activities. Comments included, "There are weekly activities, they take them to a day centre where there is gym, swimming, computer or if you want your nails done. Once a year they can go on a four day holiday" and "They are not sitting vegetating. There is plenty stimulation there."

People and relatives knew who to speak with if they had any complaints or issues and were confident that these would be appropriately addressed. All relatives told us that they had never raised a complaint but they all knew there was a procedure in place. Complaints received were documented with details of the complaint, the action taken, the outcome of the complaint and any recommendations or learning that could be taken from the complaint.

Domiciliary Care Service

People's care and support needs, preferences, choices, likes and dislikes had been clearly documented within their care plan. Care staff confirmed that the care plans were good documents that gave them the information required to ensure people received care and support that was responsive to their needs.

Feedback about care plans from care staff included, "Care plans are tailored to the person's individual support needs" and "The information in the care plan is quite straight forward. It tells us about their likes and dislikes."

Care plans were reviewed every month or sooner where required especially if changes were noted in the person's health and support needs. Each person was allocated three named key workers, who they knew and who were responsible for reviewing the persons care plan and risk assessments as well as reviewing their set goals and targets in relation to their health and social care needs. Each key worker shared the tasks related to the person and the key working process amongst themselves. The manager also rotated key workers periodically so that key workers got the opportunity to know each of the people they supported.

Care staff clearly understood the meaning of person centred care and were able to give examples of how they ensured people received person centred care. One care staff told us, "The person has to be at the centre of their own care and any decisions that they make." Care plans were person centred and gave a detailed insight into the person's life, their history and their desires and aspirations for the future.

Where people were noted to exhibit behaviours that challenged, each specific incident had been clearly documented on an Antecedent Behaviour Chart (ABC) chart. An ABC chart is an observational tool that is used to record information about a particular behaviour or incident. The service recoded any such incidents with details of possible triggers leading to the incident, the actions taken to support the person and the steps that could have been taken to manage the incident in order to reduce any such further incidents. This allowed the care staff team to review and analyse patterns and behaviours to ensure learning so as to avoid or improve the effect of any known triggers.

Staff adapted services and resources to the individual needs of people. For example where people were unable to communicate verbally the service used pictorial aids and communication charts in order to engage the person in making their own choices and decisions about how they wished to be supported.

Each person had, in partnership with care staff, developed a weekly activity programme which detailed a variety of activities that the person could to take part in on a regular basis. Activities included day living activities, cleaning, cooking, baking, watching television, shopping and swimming. During the inspection, people were out participating in activities and were supported to do so. One person, with the support of a care staff, had compiled a photograph diary of all of the activities and holidays that the person had participated in. The person enjoyed showing the inspector their diary and were able to talk through each of the photos explaining each of the activity that they had been involved in.

Relatives gave positive feedback about the activities their relatives were involved and how the service successfully supported them with this. One relative told us, "'He [person] goes out regularly to a day centre. He also goes on a day course. Sometimes to a pub or café. He did a cooking course."

People and relatives knew who to speak with if they had any complaints or issues and were confident that these would be appropriately addressed. The service did not have any recorded complaints. However, the complaints policy in place outlined clearly the steps to be taken to address any complaints that were raised. This included recording the details of the complaint, the actions taken, the outcome of the complaint and any recommendations or learning that could be taken from the complaint.

Good

Is the service well-led?

Our findings

Care Home

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives knew the registered manager well and felt able to approach them at any time. One person told us, "I know [Name of provider]." We saw that the registered manager and provider knew people well and people approached them with confidence. There was an open and transparent culture at the service. One relative told us, "I would recommend the place to anyone. Get them there."

Care staff confirmed that the management was good and that they were all appropriately supported through a variety of ways which included supervision, appraisal and staff meetings. Care staff told us that these support mechanisms were helpful and positive where they felt confident and able to make suggestions which were always taken on board. Agenda items discussed at meetings included, incidents, accidents, keeping service users safe and audit outcomes.

Feedback from care staff included, "She [registered manager] is kind with people and takes into account the opinion of the staff. She supports me", "We are here to learn and improve. They [management] always give us advance notice of meetings so that we can prepare our own agenda" and "She [registered manager] is very good, very calm and takes her time to explain things."

The provider and registered manager had a number of systems in place to monitor and evaluate the quality of care and support people received. This included six monthly provider audits, medicine audits, monthly premises audits and monthly care plan checks. This allowed the provider and registered manager to learn and make the required improvements to the quality of care being delivered where required. We did note that the registered manager did not record the outcome of the monthly care plan checks. We highlighted this to the registered manager and provider and although we did not have any concerns in relation to the care plans, the registered manager confirmed that they would ensure all checks were recorded for the future.

Residents meetings were held on a monthly basis where people were invited and involved to have discussions about advocacy, complaints, safeguarding, food and activities. People, relatives, and other stakeholders were also encouraged to engage with the service through the completion of annual satisfaction surveys or the provision of a suggestion box at the entrance of the home so that everyone could give feedback as and when they wished. This enabled the provider to identify areas of concern or where the delivery of care and support needed to be improved. Stakeholders who had completed satisfaction surveys included GP's, care co-ordinators and therapists. The provider had collated all information received and had devised an action plan detailing the improvements they planned to implement and the timeframe in which

the work would be completed. We saw records confirming that the action plan was reviewed every month.

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals including psychiatrists, the day centres that people attended, advocacy services, therapists and the GP.

Domiciliary Care Service

There was a registered manager in place at the time of this inspection. However, a second manager had submitted an application to the CQC to become the registered manager of the regulated activity 'personal care' so that the registered manager overall would then be the registered manager solely of the regulated activity of 'Accommodation for persons who require nursing or personal care'.

The service provided the regulated activity of 'personal care' within two supported living schemes. Each scheme had a scheme manager who was responsible for the day to day management of the services and who would report to the manager, due to be registered and the area manager. People and relatives told us they knew the scheme managers who were always available and approachable for any questions and queries they had. One scheme manager told us, "Relatives visit quite often and they contact me if they need anything."

People, relatives and a variety of stakeholders were provided with a number of ways in which they could provide feedback about the care and support that they received or which was provided by the service. This enabled the service to monitor, evaluate, learn and improve people's experience of the care and support that they received. Processes included annual satisfaction surveys and a compliments book. Surveys that had been completed were positive. A support worker at a day centre who had completed the survey had written, 'Staff support is excellent. The service is meeting [person's] needs at the moment. She is very happy.' Comments noted in the compliments book included, '[Person] was in a good mood. He was doing well' and '[Person's]mother says [person] is looking good.' The provider ensured that all completed surveys and received comments were analysed and where issues had been identified, recommendations for improvement had been put in place and addressed.

Care staff were complimentary of the support and guidance that they received from the scheme managers and other senior managers. Staff told us that within the whole team there was an open and transparent culture which empowered them to progress as well as promoted honesty and inclusion. They told us that they regularly received training, supervisions and appraisals and also attended daily handovers and monthly team meetings which gave them direction, information and guidance on day to day issues and operational matters. Agenda items included feedback, service users, staff task allocation and cleanliness of the schemes. Care staff confirmed that they were always empowered to speak up at meetings to give their ideas and suggestions and that these were listened to. One care staff told us, "We have them every month. We talk about what we need and any concerns. We work together as a team."

The scheme manager at one service had introduced care staff awards to recognise the hard work and dedication of the care staff that support people. Two awards had been awarded to care staff for outstanding performance and contribution and most helpful staff member. The scheme manager told us, "We keep a nice and friendly relationship with our staff. We have to value them." One care staff told us, "We are so well looked after by the manager. They give us opportunities and promote from within."

The provider also organised annual director forums which involved all of the directors and senior managers. The meetings took place on a rotational basis at each of the schemes which gave the provider an

opportunity to meet with the people living at the scheme and the care staff. We saw minutes of these meetings which discussed how people were and how the service was progressing. The provider also engaged with each of the senior managers and scheme managers at monthly service development meetings which looked at policy and procedures, guidance updates and current legislation.

The provider and scheme managers had a number of systems in place which monitored the quality of care and support that people received as well as the environment and health and safety of each of the schemes. This enabled the service to ensure continuous learning and improvement in service provision. This included medicines audits, premises checks and care plan checks. The provider also completed a six to nine monthly provider compliance checks. Any issues identified were translated into an action plan which detailed the actions to be taken and the date the actions were addressed. We did note that the scheme manager did not record the outcome of the monthly care plan checks. We highlighted this to the scheme manager and area manager and although we did not have any concerns in relation to the care plans, they both confirmed that they would ensure all checks were recorded for the future.

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals and social activity centres. This included social workers, learning disabilities team, day and leisure centres.