Community Integrated Care

Glendyke Road

Inspection report

54 Glendyke Road
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Date of inspection visit:
22 October 2016

Date of publication:
06 January 2017

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 22 October 2016. The inspection was unannounced. Glendyke Road is a privately owned care home that provides accommodation and personal care to three adults with Learning disabilities or autistic spectrum disorder. The home is located in the Allerton area of Liverpool and is operated by Community Integrated Care. The property has three large bedrooms, a lounge/dining room, kitchen and a small room which is used as an office. There are grounds to the front and rear of the property. At the time of our inspection, three people were living at the home and receiving the service.

The service had a registered manager in place at the time of our inspection and a service leader. 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 2008 and associated Regulations about how the service is run. We were supported during the inspection by the service leader.

The registered provider completed some quality assurance checks to evaluate and improve the service. However, these were not always effective in their purpose and were not focused uniquely on Glendyke Road. Actions identified did not include timescales for implementation or review that ensured the measures implemented were effective in improving the service for the people who lived there in a timely manner.

The registered provider told us they completed 'Quality Annual Satisfaction' surveys with people living at their home, their relatives, care workers and other professionals involved in people's care and support. However, this information was not provided when requested. The registered provider was unable to demonstrate how they actively sought and reviewed feedback that ensured they delivered high quality care or where they had implemented any actions as a result that had led to improvements in the care and support people received.

We saw that a medication audit had been completed but we did not see any additional audits or checks to demonstrate that the registered provider was assessing, monitoring, and improving the quality of service provision or that feedback from people was being used to evaluate and improve services.
Systems and processes that ensured staff had access to supporting guidance, policies and procedures were not effective. During our inspection, this information was not always available or up to date.

The above concerns meant that at the time of our inspection systems and processes implemented to assess, monitor and improve the quality and safety of the services provided had not been fully established and were not always effective in their purpose.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were followed and staff were provided with regular supervision and support.

During our inspection, care workers told us there were not always enough full time permanent staff employed to ensure people were kept safe and their needs were met at all times. The registered provider did not use a staffing dependency tool to ensure sufficiently suitable and competent staff were on duty at all times. We have made a recommendation regarding this.

Risks associated with people's care, support and the home environment were effectively assessed and managed. Medicines were managed safely and people received their medicines as prescribed. People were supported to eat and drink enough. People had access to holistic healthcare from a variety of health professionals and people's health needs were monitored and responded to.

People were supported by staff who had the knowledge and skills to undertake their role and meet people's individual needs.

People were supported to make informed decisions and where a person lacked capacity to make certain decisions the registered provider acted under the Mental Capacity Act 2005. This helped to ensure any decisions made were in the person's best interest and that the least restrictive option was followed.

People were provided with information in a way that was accessible to them and staff had a very good understanding of how people communicated their agreement, preferences and wishes.

Staff were kind and compassionate and treated people with respect whose rights to privacy and dignity were promoted and upheld. People and their families were supported to raise concerns or complaints and were told us these would be responded to.

People and their families were involved as much or as little as they wanted to be in planning their care and support, staff knew their individual preferences and tailored support to meet their needs.

People were encouraged to make choices about their care and support and they were supported with a range of activities and interests including foreign holidays and excursions.

The service had a warm, friendly atmosphere and had an open culture for providing people with the best quality of health and life opportunities. There was a clear staffing structure and management and staff understood the requirements of their role.

We evidenced the registered provider was in breach of one of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The registered provider did not use a staffing dependency tool that ensured sufficient numbers of staff were on duty at all times to meet people's needs and keep them safe.

There were systems and processes in place to minimise the risk of abuse, but supporting guidance for this was out of date.

Risks associated with people's care and support were effectively assessed and managed.

People received their medicines as prescribed and these were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who received training, supervision and support.

People were enabled to make decisions. Where a person lacked capacity to make a certain decision the registered provider had acted under the Mental Capacity Act 2005.

People were supported in the least restrictive way possible.

People were supported to eat and drink enough.

People had access to healthcare and their health needs were monitored and responded to.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with respect. People's rights to privacy and dignity were promoted.

People were provided with information in a way that was

accessible to them and staff had a good understanding of how people communicated.

People were supported to express their views on their care and support at all times.

People's preferences and wishes for their end of life had been discussed and this was documented.

Is the service responsive?

Good

The service was responsive.

Where possible people and their families were involved in planning their care and support.

People were supported to have a social life and to pursue their interests and other activities of their choosing.

Systems and process were in place to receive and respond to complaints and action would be taken to resolve these.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems and processes implemented to assess, monitor and improve the quality and safety of the services provided had not been fully established and were ineffective in their purpose.

Records used in the management of the home for example, policies and procedures were not always available or up to date.

Relatives spoke highly of the service received by their family members.

The management and staff team were open, approachable, warm and friendly.

Glendyke 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 22 October 2016 and was unannounced. The inspection was completed by one adult social care inspector.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and we contacted the local authority for their feedback on the service.

The registered provider submitted a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spent time observing people receiving services in their home and we had some interactive conversation with two people who lived there. We interviewed two care workers and we spoke with the service leader. We looked at records, which related to people's individual care; this included the care planning documentation for the three people who lived at the home. We also looked at two workers recruitment and training records, the care worker rotas, records of audits, policies and procedures and records of meetings and other documentation involved in the running of a residential home.

After the inspection, we contacted three relatives of people who lived at the home for their feedback on the service their relatives living in the home received.

Requires Improvement

Is the service safe?

Our findings

The registered provider told us on the PIR, 'The home is based around the needs of the people we support, the staffing rota reflects this and on the occasion bank staff are needed to be brought in to cover an absence; bank staff are familiar to the people supported and will always be working alongside a regular member of staff.' We looked at the rotas for the previous three weeks. We found two care workers were on the early morning shift, two people were on the late shift and one person was available at night.

During our inspection, two full time staff and one student nurse provided care and support to the three individuals. A care worker told us, "Staffing is ok as long as there aren't any problems but it can be difficult when we are trying to assist people with activities or take them on trips out; we really need three people on those occasions." Another care worker said, "There are not really enough staff, it's ok when people go out to the day centre where they are supported by those staff but when we are supporting a person with an activity we struggle." People living at the home required two carers to support them with their daily activities that included personal care.

We spoke with the service leader about these concerns and they said, "We have access to bank staff that we bring in when they are needed to help out." They continued, "I live around the corner and when not on duty, I am available on call if required." They told us they were looking to change the registration to a supported living scheme and would be reviewing the number of staff once this had been completed. We asked how staffing numbers and skills were determined to ensure that enough staff were on duty to meet people's individual needs both in the home and when out in the community. The service leader told us they did not use a staffing dependency tool to determine staffing levels but said staffing was discussed at team meetings.

The registered provider told us they were going to review staffing once the registration had changed. Whilst it is recognised that the registered provider is trying to change their current registration, we recommend that the registered provider seeks guidance and advice on the use of a staff dependency tool and reviews their staffing numbers accordingly.

During our inspection, the registered provider told us there had not been any safeguarding incidents to record. The registered provider had a file that contained a policy, procedure, and additional guidance that helped care workers to decide when to escalate any concerns by using a local authority threshold tool. We found that the information was out of date. One policy was dated 2011 and the other 2013. We spoke with the service leader about this and they told us, "Staff have access to up to date policies on line, we have updated the safeguarding policy and it needs replacing in the file." The service leader provided us with an up to date copy after the inspection.

The registered provider had completed pre-employment checks on care workers that helped to ensure they were of suitable character to work with vulnerable people. These checks included two references and Disclosure, and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable

adults. It was clear from files that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work at the home.

We spoke with two relatives of people who lived at the home and they told us they felt confident their relatives were safe in their home at Glendyke Road. They said, "The home is brilliant; if there are any concerns about [Name] being safe the manager will ring me straight away." "I don't have any concerns, [Name] has a regular group of staff who are very caring and the manager always rings us with any concerns about [person's] safety; communication is very good." There were systems and processes in place to minimise the risk of abuse and staff had received training to recognise and protect people from abuse and avoidable harm. Staff we spoke with had a good knowledge of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the registered manager or the service leader and escalating concerns to external agencies if needed. One member of staff we spoke with said, "I would go to the manager first and then to a manager at a higher level. There is a whistleblowing number we can ring too, or I could go to you (CQC)." Information was available for care workers to undertake whistleblowing. Whistleblowing is used by employees to confidentially disclose information that is in the public interest and workers are protected from reprisals by the Public Interest Disclosure Act 1998. This meant systems and processes were in place to keep people safe from avoidable abuse and harm.

The registered provider undertook regular checks on the home and environment. We saw a fire safety file with risk assessments; these were up to date and had been reviewed annually. Weekly recording of fire alarm tests and checks on emergency lighting and fire extinguishers was also documented and up to date. Care workers told us and we saw from their files that they had received fire training and had completed a fire awareness workbook. A fire safety policy and procedure was available as a point of reference, however, this was dated August 2010 and had not been updated. The service leader told us and we saw from a policy list, that this was under review. This meant information to guide care workers as a point of reference in a fire emergency did not contain relevant up to date information. You can see what action we took by reading the well led section of this report.

People's care plans contained individualised information about how to keep people safe at home and in the community. Risk assessments were included in care plans and detailed risks relating to people's support and how they should be managed. Information was balanced with promoting people's independence. Risk assessments were personalised to each individual and covered areas such as travel, personal care, health and activities. We saw this information formed the basis of a support plan for the given activity that included guidance for care workers on how to action the support. This information had been reviewed for effectiveness in keeping the person safe. For example, we saw risk assessments were in place for the use of bed rails to keep people safe at night. The registered provider had reviewed the use of bed rails with a local community health team and because of feedback had removed the rails, and replaced them with foam wedges. Further assessments of the use of bed wedges demonstrated they were the least restrictive option and people had not fallen from their beds since they were used. This meant the registered provider had systems and processes in place to keep people safe from avoidable harm and practice was reviewed with input from other health professionals.

The registered provider had a health and safety policy and procedure dated Oct 2013. The service leader told us and we saw this was under review. There were systems in place to assess the safety of equipment and the environment. The registered provider completed documented checks that included first aid boxes, electrical equipment, wheelchairs, call system, beds, mattresses, covers, hoists and slings. Any concerns highlighted were rectified using maintenance contracts and service level agreements with external contractors to ensure equipment was maintained and everybody at the home was kept safe. Other certificates for safety checks were in place for the electrical installation, gas safety, portable appliance

testing and the risk associated with Legionella. Showerheads and hoses were dismantled and descaled and these checks were recorded and up to date. An infection control policy and procedure was in place and had been updated. This provided guidance and information on prevention and control of infections and on types of disease and infection to look out for and what to do to mitigate the associated risks.

Accidents and incidents were recorded and outcomes were evaluated to mitigate re-occurrence. Staff were kept safe whilst accessing the home by a hazards risk assessment. This identified the hazard and included who could be at risk, measures to minimise the risk, further action required and this was dated, actioned and reviewed.

An emergency response file was available and contained advice and information on what to do in emergencies. This included personal emergency evacuation plans (PEEP) for people. PEEPs are documents, which advise of the support people need to leave their home in the event of an evacuation-taking place. There was a risk assessment in place to assess the risks associated with new staff and visitors to the home. Actions to minimise the associated risks included guidance on ensuring individuals were not left on their own with people who lived there. The above systems and process helped to ensure the home, environment, equipment was safe for everybody, and meant people were kept safe from avoidable harm.

Systems and processes in place to manage and administer medicines for people were effective in their purpose. People had received an initial assessment that identified the level of support they required with any medicines. The registered provider had an up to date policy and procedure that included reference to CQC Fundamental Standards and NICE guidelines. The document provided users with links to infection control policy and procedure and health and safety guidance and provided holistic information on the management and administration of people's medicines.

We saw from people's daily life files that medication records included a photograph of the person and a medication profile. The profile included details of the name of the medicine, a description, administration guidance and a background to the medication. Details were also recorded to advise staff of any allergies the person had. Other information was included in a support plan for medication that was taken as and when required (PRN), for example paracetamol and support plans with body maps were used that provided guidance with the application of creams.

People were given their medicines as prescribed by their doctor. We observed people being given their medicines and this was done safely and discretely, respecting the person's privacy. All medicines were accurately recorded on a medication administration record (MAR). We saw the process had been audited in October 2016. Where concerns were found with any part of the process we saw corrective actions had been implemented to mitigate re-occurrence.

Good

Is the service effective?

Our findings

Care workers had completed their own one-page profile and we saw this documented in their personal files. The information included a photograph and details about what was important and how to support them in their role as a care worker. The service leader told us, "We use this information to try and ensure staff are a good match with people." On the PIR the registered provider said, ' All people supported, benefit from a long term staff team.' and 'They [staff] are aware of each individual's needs, their likes and dislikes and most importantly their strengths and they encourage as much as possible with their independence.' A family member we spoke with said, "There are three long term members of staff and they have provided care and support to [Name] for many years." They said, "The three staff are absolutely fantastic, they really understand [Name] their needs, when they are happy, angry or upset; it makes our lives so much easier knowing [Name] is understood and well cared for."

Staff we spoke with told us that they felt supported and confirmed they had regular supervision meetings. The service leader said and records showed that new care workers completed an induction programme that was followed by a probationary performance review after six weeks. The induction programme for new employees was based on the care certificate and provided the employee with basic training on providing safe, compassionate care. Existing employees had been supported to complete national vocational training levels two and three in health and social care.

Training was electronically recorded to ensure care workers were up to date with areas of learning that included moving and handling, management of actual and potential aggression (MAPA), emergency first aid, safeguarding, medication administration and care workers completed a medication competency assessment. These were areas of learning which the registered provider considered mandatory for all staff. This helped to ensure that care workers had the appropriate skills and knowledge to meet people's individual needs. A care worker said, "Training is a mix of on line, theory and practical and is dependent on what we need." They said, "I have completed health and safety and also training in epilepsy so far this year."

Relatives of people who received care and support told us that they thought that staff had the skills and knowledge required to support their family members. One relative told us, "I don't know what training staff have but they all appear to be well trained and knowledgeable about the work they do."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

We did not see where care workers had received training in the Mental Capacity Act 2005 (MCA). However, care workers we spoke with understood the Act and how it affected their daily working with people who had an assessed lack of capacity. People were supported to make decisions on a day to day basis. We observed staff enabling people to make informed choices and gaining their consent. We saw that staff had a good

understanding of how to communicate with each person. People's care plans clearly detailed how to support people to make decisions to maximise their opportunities for choice and control. People's support plans contained clear information about whether people had the capacity to make their own decisions. We saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed. Health workers involved with people's care had carried out capacity assessments around finances and the registered provider was waiting for the final paperwork from the local authority. The service leader told us "We have made numerous requests for the paperwork to be returned but people supported can give consent to the care and support staff provide."

The registered provider told us on the PIR, 'It is very difficult for the clients we support to make major decisions around what care or treatment they require, although we do explain everything to them, we always involve other health professionals and ask family members to contribute.' 'It is very important to us that we are always acting in the person supported best interests; all major decisions would be made involving all other relevant health professionals involved in the person supported care and a family member or IMCA.'

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service leader had submitted applications for DoLS where appropriate, to ensure people were not unlawfully deprived of their liberty. We saw applications had been submitted where people lacked capacity with their personal care, mobility, nutrition and social life. The local authority had provided a 'priority tool' that gave guidance on how quickly the applications would be processed.

Care workers were given training on how to respond to behaviour using least restrictive methods however, they told us, "People living here don't pose challenging or aggressive behaviour, but if they did we would use de-escalation techniques and restraint would only be used as a last resort if their or other people's safety was at risk." At the time of our inspection, no restraints had been carried out on anybody living at the home.

We saw peoples dietary requirements were noted in their care plans, which included details of food preferences, and information on supporting people with good nutrition and hydration. One care plan documented the person's choice of food, their likes and dislikes, which included rice. This had been reviewed and had identified that the person liked rice but only with curry.

Other information included support for a person who was assessed as at risk from choking. The registered provider had engaged with a speech and language therapist (SALT) who provided advice on types of food and how to prepare meals that ensured the person was supported with their dietary requirements. Additional information and guidance had been provided from the Mersey Care NHS foundation trust, who had implemented a support plan that included food preparation techniques and the required positon of the person to be in to avoid choking.

A 'day to day' file contained further information and guidance for care workers. Information had been completed that recorded what the person had to eat and drink each day and bowel movement records. A care worker told us, "We monitor and review people's dietary intake and associated health and we update care and support records to ensure people have adequate food and liquids." They said, "[Name] attends a day centre and we had some concerns they were not eating properly, so we ordered food in that is shaped

as a fish. The person takes this food with them to the day centre and we know now they have a nutritious meal that they enjoy."

Relatives told us, "[Name] will eat almost anything that can be more of a concern but everybody is fully aware and they are very well supported; they are assisted to the dining room to eat which is nice." "[Name] eats in the dining room in the kitchen area, they have their preferences and staff can understand from [persons] facial expression if they are given something they don't like but it's a learning process." These measures helped demonstrate that people gained sufficient support with eating and drinking to maintain a balanced diet.

People were supported to maintain good health. The registered provider told us, "We never compromise with any concerns especially around people's health; we always refer and seek advice and guidance from other health professionals to ensure people receive appropriate care and support to remain healthy." We saw care plans contained a record of medical appointments and individualised health plans. The registered provider had included notes from a nurse regarding care and support for incontinence and guidance was recorded to help care workers provide care and support for a person's bladder and bowel control.

Care plans included risk assessments and support plans for skin care, nail and foot care, mouth and dental care and sight. People received support from chiropodists, opticians, GP and nurses. One person's file included monitoring charts for a person's epilepsy. This information was reviewed by a GP and the person attended an epilepsy clinic to ensure the symptoms were managed effectively.

People's files contained a health passport. This included detailed information to ensure a person's care and support needs were available should they need to transfer to a different health service for example an admission to hospital.

We observed the home was easy to navigate for the people who lived there. Doorways had been widened and hard wood effect flooring facilitated the manoeuvring of equipment. The home had a pleasant calm environment and reflected people's individual needs and their requirements by the adaptions and design that had been implemented. Access was available to the outside of the building where there was a garden area and a car parking area where people could manoeuvre in and out of their vehicles.

Good

Is the service caring?

Our findings

During the inspection, we observed that care workers knew the people they cared for. They understood the importance of treating people with dignity and respect. People were addressed in the way they wanted to be and we saw they responded with positive expressions when spoken to. We asked care workers how they got to know people's likes, history and their preferences. A care worker told us, "I have worked with [Name] for a long time, this is like a second home to me" and, "We have built up good relationships, it's a very calm environment, we just do our best." Another told us, "Information about people is available in their care plans, and that information is kept up to date."

The registered provider told us on the PIR, 'Staff rely a lot on facial expressions and the tone of voice by people', A care worker told us, "People living here are very good at expressing themselves; one person likes to go for trips on trains, when we say where we are going their face lights up." They continued, "another person likes Elvis, we went to the theatre to see an Elvis show and they spent the whole time clapping their hands; it's so rewarding to see people enjoying themselves."

New care workers and staff who came into the home were not left unattended with people. They shadowed existing care workers to get to know people who lived there and to allow people to become familiar with their presence. A care worker told us, "Staffing can be difficult at times; people need continuity of people to provide their care and support." They continued, "There are three of us who have been here a long time but we could do with more long term permeant staff so we can leave them on their own with people to provide consistent support."

Family members we spoke with told us, "I don't think [Name] is left on their own at all, there is usually a couple of staff about who have worked there along time but they do have a lot of new staff; it is getting better." "The care workers provide care and support that goes beyond the day to day tasks that are involved in supporting [Name] because they have worked with [name] for so long we consider them to be part of the family."

We saw from the care plans for people living at the home that they included a section called 'My Life in Focus.' Information included any religious needs, 'high-risk indicators' and a 'lifestyle plan.' These documents provided guidance on everyday living, care and support. This information was detailed and had been reviewed which helped care workers to respond to and meet any diverse needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Care workers we spoke with told us that people, their families and advocates were involved with their care and support planning as much or as little as they wanted to be. They said, "We regularly speak with family members and invite them to meetings with the person and their key worker." We saw from care files that there was good documented communication between the registered provider, people, their families and other health professionals. Family members said, "We receive excellent communication and we are always kept up to date with [Names] progress and any concerns." Care plans included a communication sheet. We

saw this was completed and along with the daily diary, documented discussions and feedback that had taken place with family members and other professionals.

People were supported to express their views on their care and support at all times. A care worker told us, "People who live here are very good at expressing their likes and dislikes and can acknowledge their agreement or disagreement, often by facial expression or by making different noises." We observed care workers constantly communicating and discussing daily activities with people. A family member said, "[Name] relies on staff for all their daily needs, I know they would express themselves if they were not happy with something and staff would certainly understand."

Where important decisions had to be made for example, with managing people's finances, the registered provider had documented best interest meetings where decisions were made that included other professionals and family members involved with the persons lives. We asked the service leader if they used advocacy services (IMCA) to support people. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities. The service leader told us, "We can access advocacy services but we don't always need to as people have good support from family members and other professionals.

Care workers received training in privacy, dignity and confidentiality during their induction. Care workers we spoke understood the importance of maintaining people's privacy and dignity. They said, "I make sure that when I am providing personal care that the door is closed, I have towels available to cover the persons top and bottom half and check that they are in agreement with everything." We make sure we respect people's wishes and preferences; if they want the door open whilst they are in the bathroom we respect that and we make sure people are aware when that happens to avoid any embarrassing situations." "I always make sure the person's dressing gown is available to keep them covered and warm and we all talk everything through as we are going along."

The service leader told us, "We have a small team of staff so it's quite easy to ensure best practice is being followed; if it is not we have access to training and everybody is supportive of each other too." "Everybody understands the need to maintain people's confidentiality; discussions are held privately in the persons room and nothing is discussed outside the home."

People's preferences and wishes for their end of life care and support had been discussed with family members and the person and this was documented. The information included a detailed funeral plan and was confidentially kept in the person's room. This meant everybody understood what would happen at this stage of a person's life and that his or her preferences would be acted upon.

Good

Is the service responsive?

Our findings

Each person who used the service had an individual support plan. People who used the service were not able to be actively involved in the development of their care plans but it was clear from the person centred nature of these that they were based upon staff learning what was important to each person and how best to support them.

Care plans contained holistic information about the person. Information had been reviewed and updated. The service leader told us updates and reviews were completed as people's needs changed or as a minimum every year. Reviews were completed with everybody involved with the person and their care. If agreed by people living at the home, relatives were also involved in developing people's support plans. The relative of one person told us, "Yes I do see care plans, we are not really involved in their reviews but maybe it's something we need to do more of; we see [Name] daily and staff do a great job so we are quite happy with everything as it is."

Care plans contained clear information that was centred on the person. A one-page profile provided the reader with an instant overview and contained basic important information. This included a photograph of the person, and a brief background on the person's likes and what others admire about the person, what was important to the person and how best to support the person. A 'Getting to Know Me' section detailed people's food choices, dietary needs, health and wellbeing, medication and financial support. Another covered 'To support me successfully you need to know…' and this provided information and guidance for staff on how this was carried out. For example where a person was registered blind, guidance included the use of walking aids, a hoist and walking with the person on footpaths. Where guidance had been provided this was reviewed and documented under 'What we have learned' to help tailor the care and support to the persons individual requirements.

The registered provider told us on the PIR, 'We use communication passports and also hospital passports. These record how the person communicates their needs and also the health support needs along with their wishes in relation to their health and treatment.' 'This ensures that their wishes and needs are respected in an emergency situation where their rights might otherwise be compromised.' This enabled people to receive consistent co-ordinated care should they need to move between different services for example a hospital admission.

It was clear from entering the home and people's rooms (with their permission) that they had personalised areas of space. Furniture ornaments and decorations were representative of their interests and hobbies. One room had pictures, images and models of transport vehicles. Another had Elvis memorabilia and a comfortable chair where the person could listen to their favourite music. People had daily routines and these were documented in their care plans as a reference point for care workers to follow.

People were supported to be active and to participate in a range of activities. One person liked to go to a day centre three times a week and enjoyed aromatherapy sessions, the theatre, meals out, socialising and music. A relative told us, "[Name] had never been on holiday abroad so we saved up some money and paid

for them to go to Spain." They continued, "They [registered provider] were absolutely fantastic in supporting the trip; the care workers paid their own fare and [Name] had a fantastic time, it was such a wonderful experience for [Name]. The registered provider showed us pictures of the holiday, which the person kept in their room. Another person told us, "[Name] likes to spend time in their car and to make sure this can continue we have met with the manager and [Name] is now paying a bit more out of their allowance to have this but it's worth every penny to see them happy."

External links were seen to be in place with A.C.E. (Active Community Enterprise) a community-based support agency for adults with learning disabilities. A care worker told us, "ACE provide people with learning disability to undertake activities such as going to the pictures or a disco, it's not always free but for a small admission fee we can help people enjoy alternative activities."

A care worker told us, "We try and provide a life for people beyond just care and support, we do manage this but we could do more if we had more permanent staff." They added, "[Name] likes to go out and feel the fresh air on their face, sometimes it's just to the park; I wish we could do this more but it is dependent on who is on shift." The service leader told us they were in the process of changing the registration details for the service and were looking to review staffing once this had been completed.

People were supported to maintain relationships with their families and friends. People's care plans included information about individuals who were important to them. A relative told us, "We have no restrictions on when we can visit [Name], whenever we go everybody seems happy to see us." They said, "[Name] is quite happy and they are aware when we visit."

We asked relatives how they would raise any concerns or complaints. They said, "We had a complaint several years ago, we followed the systems and procedures; it took some time to sort out but I think we are there now, [Name] is safe and that's what really matters. Another relative said, "I don't have any complaints and if I am honest I would not change anything, the three regular staff are great, we could do with more of those [regular staff] but other than that [Name] is in a good place."

At the time of our inspection, the registered provider had not received any complaints. The registered provider told us in the PIR, 'Any complaints at Glendyke would be swiftly responded to and acted on accordingly, a complaints procedure is readily available and an easy read and picture version, is in each personal file and would also be available in audio if needed.' Information was also available in people's care plans in an easy read format. Having information available in different formats makes it more accessible and easier to understand.

Requires Improvement

Is the service well-led?

Our findings

We looked at the systems and processes the registered provider used to assess, monitor and improve the quality and safety of the service provided including the experience of service users.

The service leader had completed a service quality assessment tool (SQAT) and submitted this back to the area office in January 2016 for further evaluation, analysis and feedback. The service leader also completed and submitted a monthly transformation action plan to their manager that highlighted what had happened in the service over the previous month. However, this information was not unique to Glendyke Road and we did not see how this information was evaluated to improve the service for people. We looked at the information in the SQAT. Feedback included a rated evaluation of the service with identified areas that required further improvement. However, the information did not include any timescales for implementing the improvements required or for completing the actions identified. We were not provided with any additional information on how or if this information had been implemented into the service or how the effects of the changes had been monitored and reviewed for their effectiveness.

Some of the policies and procedures in place in the home were out of date and did not include the most relevant information. Others, which we requested, were unavailable. Where we requested updated copies, these were all provided after the inspection or we were informed they were under review. The service leader told us in an email after the inspection, 'Many of our policies are now due their next review in the cycle, and we have now taken the opportunity to review how effective this current approach is.' 'As a result, we engaged with an external consultant who has said that we could further simplify the policies and strengthen our governance and that we could do this at the point of natural review cycles.' This meant staff had access to up to date guidance and information that helped support them in the role.

We looked at how the registered provider ensured they delivered high quality care that consistently sought and reviewed feedback from people living at their home, their relatives, care workers and other professionals involved in people's care and support. The registered provider told us on the PIR, 'Quality Annual satisfaction surveys will be reviewed to ensure that actions are addressed and good practice is recognised and celebrated.' We asked the service leader for feedback from any consultations, surveys or other feedback that had been actively sought along with any actions implemented however, this information was not provided.

During our inspection, care workers told us there were not always enough full time permanent staff employed to ensure people were kept safe and their needs were met at all times. The registered provider did not use a staffing dependency tool to ensure sufficiently suitable and competent staff were on duty at all times.
We saw that a medication audit had been completed but we did not see any additional audits or checks to demonstrate that the registered provider was assessing, monitoring, and improving the quality of service provision or that feedback from people was being used to evaluate and improve services.

The above concerns meant that at the time of our inspection systems and processes implemented to assess,

monitor and improve the quality and safety of the services provided had not been fully established and were not always effective in their purpose. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

There was a registered manager in place. We received positive feedback about the leadership and there was a high degree of confidence from families and care workers in how the service was run. Care workers we spoke with told us the registered manager and the service leader were approachable open and honest.

There was a clear management structure in place and care workers had an understanding of their roles and responsibilities. Management knew about their registration requirements with the Care Quality Commission (CQC) and were able to discuss notifications they had submitted.

Care workers told us the service had a positive open culture. A care worker told us, "It's like a family, the manager is always approachable and when required they always seek support from professionals to make sure everything is as it should be for people." Another told us, "It's more than a job, we really care about the people who live here and we want them to have the best life possible."

We saw that peoples care and support was centred on around the individual person and people were encouraged to live as full and healthy lives as was possible and care workers were seen to go over and above in supporting people for example by assisting with foreign holidays and trips out, often at their own financial expense.

Care workers told us they were supported and kept up to date with changes, not just for people but also in best practice and organisational changes. The home held house meetings that included staff and the people who lived at the home. Minutes from the last meeting documented holidays, wellbeing and birthday celebrations. Other areas of practice were discussed that included confidentiality, health and safety and safeguarding. A care worker told us, "We use these meetings to discuss just about everything that's happening in the home; they are a good opportunity to sit, think about and discuss our role and the people we support."

The registered provider had a statement of purpose dated January 2016. We saw this included information about the service, employees and provided information on the complaints process.

Care workers and relatives of people using the service told us the registered provider worked effectively with external agencies and other health and social care professionals to provide consistent care, to a high standard for people. We saw this was evidenced in people's care plans. The registered provider worked with a range of services and health professionals including the local authority, local GP practice, district nurses, CPN's, NHS trusts and speech and language therapist. This helped to ensure a multi-disciplinary agency approach was used to meet peoples care and support needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Assurance and audit systems and processes were ineffective to assess, seek and act on feedback, monitor and drive improvement in the quality of the service provided. Evaluation of the audit systems was not robust. Actions highlighted through quality assurance processes had not been reviewed or implemented within timescales or assessed for their effectiveness in improving services provided. Up to date guidance including policies and procedures for the management of a regulated activity were not always maintained or up to date as a point of reference for employees. Regulation 17 (1) (2)(a)(d)(e)(f)