Turnberry Services Limited

Manor Park

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?	Requires Improvement

Summary of findings

Overall summary

Manor Park is a large, adapted three storey terraced house in Whitley Bay town centre, close to local amenities and the beach. The service is registered to provide accommodation, personal care and support for up to 14 adults who have mental health related needs and/or a learning disability. At the time of our inspection the home was fully occupied.

This inspection took place on 1 and 2 February 2017 and was unannounced. This was the first rated inspection of the service since its registration with the Care Quality Commission (CQC) in March 2015.

The service had a registered manager 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 told us that they felt safe living at Manor Park with the support from the staff. Policies and procedures were in place and up to date to ensure staff understood their responsibilities and to assist them to support people with the most appropriate approach.

Records were kept regarding accidents and incidents including those of a safeguarding nature. Incidents were recorded, investigated and reported in a timely manner to other relevant authorities such as the local council or CQC. These were monitored by the registered manager and used to review care needs, risk assessments and implement or improve preventative measures.

The service managed risks associated with the health, safety and well-being of people, including carrying out regular checks of the property, equipment and utilities in line with their legal responsibilities as the landlord. Individual care needs had been assessed for risks related to aspects of daily living and we saw evidence in care records which demonstrated these were reviewed regularly.

Medicines were administered and managed safely and medicine administration records were well organised, detailed and correct. Medicines were stored in a safe and secure place in line with best practice guidance. The staff followed a strict policy and procedure regarding the receipt, storage and disposal of medicines.

Staff told us they felt there were enough staff employed by the service to meet people's needs; people and their relatives confirmed this. Staff records showed the recruitment process was robust and staff had been safely recruited. Training was up to date, and the staff team had a mix of skills, knowledge and experience. Staff had opportunity to enhance their knowledge further and all were qualified in health and social care.

Staff were supported by the registered manager through supervision and appraisals which were held regularly and documented. The registered manager observed staff performance on a daily basis; however

competency checks were not currently undertaken to formally assess the staff's suitability for their role. Staff and 'resident' meetings took place and we were able to review the minutes of previous meetings. Relatives were welcome to contact or visit the service. This meant everyone with an interest in the service had a chance to speak to the management and raise any issues.

The Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their liberty. We found the provider was complying with their legal requirements and applying the principals of the MCA.

People enjoyed nutritious, well-balanced meals which were prepared by the staff. We observed everyone enjoying their food at mealtimes. People had choice around mealtimes but often ate one of the planned meals from the menu, although other options were available if they preferred. People's individual nutritional needs were met. The service involved external health professionals as necessary to meet people's changing needs and to promote their general health and well-being.

Staff were kind, caring and compassionate and people told us the staff and the management were nice to them. Staff knew people well and we observed staff treated people with respect and they ensured people's dignity and privacy were maintained. People described a "happy atmosphere" within the home.

Person-centred care plans were in place. People's individual needs had been initially assessed and were periodically reviewed with the involvement of the person, any relatives and external professionals. Care plans which detailed the care and support people needed were up to date and accurate. They included extensive information about life history, family, school life, working life, interests and hobbies. Where appropriate people had consented to the care and support they received and some had been involved in writing the plans which included their own personal goals.

A newly employed activities coordinator encouraged and promoted activities which reflected people's hobbies and interests. A generic activity programme was devised which the whole staff team encouraged people to participate in to reduce social isolation and boredom. Most people were independent and accessed their local community as they wished, however others were supported by staff to get involved in external activities which they showed a keen interest in. Staff helped people to engage in a social life with family and friends.

There were a low number of complaints received by the service, which the registered manager kept a record of. She explained to us how the complaints procedure was shared with people, relatives and external professionals which detailed how complaints were investigated and managed. People told us they had very little to complain about but would feel confident to tell the staff or the management if something was wrong or upsetting them.

Regular quality monitoring had taken place until recently. The registered manager had not overseen these checks and subsequently had not realised that these checks were overdue. However we did not find any issues with the safety and quality of the service.

The service asked people, relatives and staff for feedback. Surveys had been issued to people annually to gain their opinions about how the service was managed and how it could be improved. We observed a good

response to those surveys which allowed the registered manager to collate the responses, evaluate and gather an overall opinion. We reviewed an action plan which had been produced to address the issues raised.

The registered manager and director of care operations had an extensive employment history in the care industry working with people with mental health related conditions and/or a learning disability and they were well established in their roles having known some of the people who used the service for a long time. The staff team were consistent although there had been a few recent changes to the staffing structure and recruitment was on-going to fill the vacancies. Staff told us they enjoyed working at the home and felt valued and appreciated by the management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safeguarding procedures were in place and these had been followed by the registered manager and staff.

Risk assessments were in place to ensure people's safety. People's individual needs had been assessed and preventative measures were in place with instructions for the staff to follow.

Staff recruitment was safe and robust. Enough staff were employed to meet the needs of the service.

People received their medicines in a safe and timely manner.

Is the service effective?

Good

The service was effective.

People's consent was sought in relation to their care and support. The registered manager ensured the principals of the MCA were followed.

Staff were suitably qualified, with a mix of skills, knowledge and experience. They were supported through regular supervision and appraisal.

People's individual nutritional needs were met and they told us they enjoyed the food provided.

Records were kept in care plans of input into people's care by external healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff displayed kind, caring attitudes and interacted positively with people. They understood and responded well to people's needs.

Staff were knowledgeable about individual people; their abilities,

behaviours and life histories.

There was plenty of choice around food, drinks and activities.

Staff understood the diversity within the service and treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care records were person-centred and all health and social care needs were assessed. Reviews were carried out regularly by keyworkers.

Activities were interesting and meaningful to each individual. Group activities ensured everyone was included.

There was a complaints procedure in place and people told us they knew how to complain. The registered manager held a record of complaints and incidents which were investigated and dealt with appropriately and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits on the quality and safety of the service had not been robustly monitored and subsequently several audits had not been completed for many months. Other checks on the service had been completed by support and maintenance staff.

There was an established registered manager in post who staff told us they had confidence in.

People and relatives thought the service was well-managed and told us the management had a clear presence.

Those involved with the service had been consulted to obtain feedback and we saw evidence that this was used to improve the service.

Manor Park

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.

This inspection took place on 1 and 2 February 2017 and was unannounced. The inspection was conducted by one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about Manor Park, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally required to inform us of.

In addition, we contacted North Tyneside's local authority contracts monitoring team, adult safeguarding team, care management teams and the local Healthwatch service and to obtain their feedback about the service. We also asked the provider to complete a Provider Information Return (PIR) prior to the inspection. The 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. All of this information informed our planning of the inspection.

As part of the inspection we spoke with eight people, seven of whom lived permanently at the service and one who stayed for short breaks. We spoke with two relatives during the inspection and contacted four more afterwards. Some people living at the home had difficulty communicating with us but we observed them throughout the inspection being relaxed and enjoying good interactions with all staff members. In addition, we spoke with three members of care staff, the registered manager and the operational care director. We reviewed a range of care records and information kept regarding the management of the service. This included looking at five people's care records, four staff files and records relating to the quality monitoring of the service.

Good

Is the service safe?

Our findings

Some people were able to tell us what they thought it meant to feel safe. Their explanations ranged from "not smoking in bedrooms" to "feeling secure like at home" and "feeling frightened if my friends left." They made comments such as, "I am around people I know, good people and I'm safe with the staff", "Yes, I do feel safe, staff help me a lot and encourage me, telling me I'm doing well" and "Yes I feel safe, the staff are champion."

Safeguarding policies and procedures were in place to assist staff and help them to protect people from abuse or improper treatment. Staff had been trained to safeguard vulnerable people harm and were able to describe to us what they would do if they suspected something was wrong. Records of incidents of a safeguarding nature were documented and monitored by the registered manager. They were also referred to the local authority and CQC in line with requirements. Staff told us they were confident with the safeguarding and whistle blowing procedures in place and that they would have no hesitation to report any issues. One support worker told us they would, "go straight to social services if the registered manager or provider were uncontactable" but that had never happened.

People's care needs had been thoroughly assessed and they had detailed risk assessments associated with them, such as around medicines and activities. We saw that individual risks to people and general risks regarding the property were detailed and were reviewed monthly. Records of accidents and incidents which occurred were kept and a register of events was produced to enable the registered manager to track trends. This information was then used to review people's care needs and update risk assessments as necessary in order to develop further preventative measures.

The provider had undertaken all of the landlord checks which are required by law, including tests of gas, electricity and water utilities. We saw evidence of these being carried out regularly by professional contractors. The home was well maintained and staff reported general repair needs verbally to the registered manager or handyman and logged issues in a repairs book. People told us staff would "call an engineer" if something was broken or "get someone to look at it." People were aware there was a handyman at the service but they felt "he was sometimes too busy." We observed that the fire alarm panel was in good working order, serviced firefighting equipment was in place and records were kept detailing practice fire evacuations. Personal emergency evacuation plans had been drafted and reviewed in the last six months. These are plans which describe the support a person may need to safely evacuate the premises. Most people could leave the building independently with some needing verbal prompts and encouragement. The registered manager told us she would review these documents imminently to ensure nobody's needs had changed.

The premises were clean and tidy. All staff were aware of the high standards of cleanliness and hygiene expected of them and a domestic assistant took responsibility for the cleaning of bedrooms and communal areas. We saw best practice guidelines in relation to infection control were followed such as the use of degradable bags for soiled laundry and colour coded mops, buckets and cloths. Staff wore personal protective equipment such as disposable gloves and aprons when assisting with personal care and

medicines, which reduced the likelihood of cross contamination.

Most people were independent with their personal care. Staff were able to describe the individual levels of support required by people who used the service and we saw this was recorded in their care plans. Staff felt the staffing levels were sufficient so long as the management were "on the end of a phone." Relatives we spoke with felt more staff were needed "on the ground" and said they didn't always think their relative was safe "due to some of the younger more disruptive residents." We reviewed the staff duty roster and saw that the service had an adequate amount of staff on duty during the day to ensure that people's needs could be met in a safe manner. Two members of staff worked a nightshift in order to ensure people and the premises were safe at night. We saw staff had a good relationship and liaised well with external authorities to maintain people's safety.

The recruitment of staff was robust and the staff records contained information which showed staff were safely recruited. We reviewed evidence of pre-employment vetting checks including references from previous employers, interview records and enhanced Disclosure and Barring Service (DBS) checks. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are employed. The staff records contained evidence of an induction, shadowing of more experienced staff and on-going training and development. This demonstrated that the service actively recruited suitable people with a mix of skills, knowledge and experience to meet the needs of the people who used the service. The staff we spoke with confirmed that the registered manager or provider had carried out all of the appropriate vetting checks prior to them commencing employment.

The registered manager discussed the use of the company disciplinary process when an issue had arisen. There was evidence that misconduct was investigated, and appropriate disciplinary action ensued. This showed that the registered manager continued to assess staff's suitability for their role.

We checked how well the service managed people's medicines needs. People told us they received their medicine when they expected to and without any issues. One person said, "Staff give me my medicine and they watch me take it." One member of support staff on each shift was responsible for holding the keys to the medicine cupboard and accountability was recorded in handover records. We saw the medicines were kept in a secure cupboard and inside the cupboard each person's prescribed daily medicine was kept in an individual storage box labelled by a pharmacist. There was a separate fridge to store medicines which required refrigeration, such as eye drops. Two members of staff checked and signed for the administration of controlled drugs (CD's). The CD's were stored in a locked safe within a separate locked cupboard. CD's are subject to tighter legal control because of their potential for misuse, for example, strong pain relief tablets or patches. We carried out a random check of the medicine stocks and the medicine administration records. We found these to be up to date and well maintained.

We observed a support worker administer medicines to two people and they talked us through the procedure and showed us records of how the medicines were handled by the service. Medicines were recorded upon receipt, any refusals or disposal of medicines were recorded, stored and returned to the pharmacy safely. Medicines which are only needed as and when required were found to be appropriately used, stored, recorded and monitored. The support worker told us that only the staff who had achieved a diploma in health and social care and had completed an additional safe handling of medicines course could administer medicine. Other staff were able to tell us about people's medical needs and any special instructions they needed to be aware of, including side effects from certain medicines. We noted that formal competency checks were not currently undertaken; however the registered manager was present at times to informally observe. We also noted from previous staff meeting minutes that plans were in place for a nurse

from another of the provider's services to undertake these formal checks as part of an improved quality monitoring system.

Good

Is the service effective?

Our findings

People told us that they felt staff had the right skills to look after them. One person said, "They talk if we need to talk about anything bothering us." Another person felt the established staff had the right skills but said, "I can't comment on the new ones [staff] yet."

All of the staff employed at the service were qualified in health and social care, having completed diplomas at levels two or three. The registered manager told us all of the staff had care experience and she enabled them to develop in their role by sourcing additional training in topics relevant to their current role, including epilepsy awareness and challenging behaviour. The registered manager herself held an adult learning teaching certificate and preferred to deliver the training in-house to the staff team herself when time allowed. All staff had received a company induction and completed training courses which the provider deemed mandatory such as health and safety, fire safety, food hygiene and Infection control. We also saw the provider had given all staff access to an online training resource which enabled the staff to complete a variety of topics online to enhance their knowledge. Staff records showed periodic refresher courses were completed. This meant people were supported by experienced and trained staff with up to date knowledge of current guidance and best practice.

Staff were able to describe how they managed people who may exhibit behaviours which challenged them. They told us they "find out the trigger and attempt distraction". They added that the techniques used, "depended on the situation" but ultimately "keeping cool" was the priority. None of the staff we spoke with had used restraint to manage a situation, however they felt that training on this aspect of their role was required. Staff told us that there had been occasions when they had needed to call for police assistance to "help with a person's behaviour."

All of the staff we spoke with confirmed they had completed a period shadowing to enable them to learn and observe from more experienced staff. The registered manager told us she regularly observed staff as they performed their duties and she had no concerns about any staff's member ability; however formal competency checks had not been recorded to corroborate this. The registered manager told us this would be implemented immediately as part of their on-going quality development plan.

Staff received regular supervision and had an annual appraisal to ensure staff had an opportunity to talk with the management team in private. Supervision sessions covered performance, people's needs and the steps they were taking towards their objectives, training needs, development and an action plan. We saw in staff records that these sessions took place bi-monthly. The staff we spoke with confirmed these meetings took place and they found them beneficial. Staff meetings were another opportunity for staff to share their views and discuss any collective needs the team may have to enable them to deliver an effective service. This showed staff were well supported to carry out their role.

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.

The registered manager and staff had a good understanding of the Mental Capacity Act (MCA) and their responsibilities. Training had been completed in this subject, however one member of staff we spoke with felt they needed their knowledge updated. The service had received mental capacity assessments from the local authority and they had conducted their own assessment of people's needs in this area and reviewed it as necessary. Care records showed that wherever possible people had been encouraged to be involved in making decisions. More complex decisions that were made in people's best interests' had been appropriately taken with other professionals and relatives involved too.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service had submitted two DoLS applications to the Local Authority in line with the principles of the MCA for people whose freedom was restricted. These applications had been granted and CQC had also been notified of these.

People told us the food was lovely. One person said, "I enjoyed my dinner" and another told us, "The food is smashing, spot on!" A third person told us, "Meals are served to you unless you are out, but then it is left for you to get later." We saw some meals which had been prepared were covered, labelled and refrigerated for a person to have later in the day. People told us their favourite meals included curries, pork pies, Sunday lunch and a variety of desserts. They all told us they were happy with portion sizes and they felt they received ample food and drinks. The registered manager told us they supported one person who was vegan, one person who was diabetic and one person who had been prescribed meal supplements from a dietician to stabilise their weight. One person told us their preference for smaller portions was accommodated. Another person confirmed that staff met their dietary requirements and would often go out and buy something they wanted in particular. Another person told us, If I bring something in, staff are happy to cook it for me and add vegetables if I want."

The provider had signed up to a programme called 'safer food, better business' which contained a self-assessment tool to measure themselves against set criteria. This guided the staff to prepare and cook food safely. There was a menu plan devised by people and staff around the likes and dislikes of people. If a person did not want the planned meal, they could opt for something else. For example, a support worker told us, "Today (person) doesn't want sausage sandwiches so they have chosen cheese on toast." Another support worker told us, (Person) brought a frozen pizza in last night and asked me to cook it for them." A relative told us they had not witnessed their relative eating at the home but knew their relation enjoyed it because they had received text messages from them stating "it [food] was nice."

The service had a 5* hygiene rating from the local authority which was displayed on the wall. We observed staff interacted well with people in the kitchen and dining room areas, assisting them to make snacks and drinks. We also observed lunchtime and teatime preparations and service. People looked forward to their meal and staff engaged well with them throughout. We saw staff encouraged people to clean up afterwards. The experience of mealtimes was relaxed and homely. This demonstrated that people's nutritional needs were effectively met.

Care records contained evidence that the service involved external health and social care professionals to maintain people's general health and well-being and when their needs changed. Records showed that staff

had communicated with GP's, nurses, social workers and specialists. Care records were updated with review notes and the information was fed back to relatives by telephone or email where appropriate.

People moved safely around the home and we saw that some parts of the property had been adapted to meet the needs of the people who lived there, such as additional hand rails fitted and walk-in shower areas. Most bedrooms had been personalised by people and appeared cosy. Staff encouraged people to make the home personal and inviting. Communal areas were decorated in a warm and comfortable fashion with soft furnishings and framed photographs on display of people enjoying activities together.

Good

Is the service caring?

Our findings

People said they were happy with the care they received. Comments included, "Yes, I am happy, I can always talk things out with the staff" and "It could be a lot worse, I feel lucky being here." People thought staff were caring and kind by "just being there and asking how I am." Relatives told us the staff were "nice people."

People told us they were "well looked after" and "staff make sure we get what we want." One person felt the service had helped them a lot. They told us that their health was improved; they had been helped to reduce their alcohol intake and have a better diet. They added, "My thoughts have improved and my speech is better too."

We observed lots of pleasant interactions between people and staff. We saw people enjoyed a friendly and positive relationship with the staff on duty. It was apparent throughout our inspection that boundaries had been established so people knew the expected standards of behaviour within the home and the staff were very good at managing situations and maintaining the positive relationship within those set boundaries. For example, implementing distraction and calming techniques when people became anxious.

At the beginning of our inspection, a support worker introduced us to people and asked their permission for us to have a tour of the home. We observed the atmosphere was relaxed and friendly. People and staff welcomed us and engaged with us in a casual manner. The home was clean, pleasant and informal. People were moving freely around the home, some going out, some in communal areas with friends and other preferring to stay in their rooms. The registered manager described the service as, "a family unit, homely not a care home."

The staff interacted well with people who were getting ready to go out for the day. The staff displayed considerate attitudes as they encouraged appropriate outdoor clothing for the weather conditions. Staff spoke with people in a well composed manner, showing them respect and valuing their input into conversations. We saw staff promoted independence by encouraging people to do tasks for themselves. One person told us a support worker had told them, "You have come on a lot, don't doubt yourself." This had made them want to be more independent.

Discussions with the registered manager revealed that people who used the service had a very diverse range of needs and in particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. The service was accommodating of this and staff responded well to the diversity within the home and understood the importance of treating people individually. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this. Records showed positive plans were made to ensure people's needs were met in a way which reflected their individuality and identity. Staff had not yet undertaken equality and diversity training, however this was available to them via the online training resource.

People were involved in all aspects of their life; we saw people had been involved with decisions about the

decoration of the home and of their bedrooms. People had chosen which activities to get involved with and made their own plans and decisions about going out and accessing the community. Where appropriate, people had been involved in setting personal goals which we observed in their care plans. For example, reducing alcohol intake, reducing tobacco consumption and following a healthy diet plan.

Due to people's complex needs, all of the people who used the service had some form of an advocate. This was usually an external professional such as a specialist support worker or social worker. Family members were also involved with supporting people. The registered manager told us that formal independent advocates from the local authority had been involved with people in the past. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Personal and sensitive information was kept locked away in cupboards within the office area. The staff were aware of the importance of maintaining confidentiality and privacy within the home. We saw staff upheld people's privacy and dignity. A support worker explained to us that everyone liked to keep their bedroom doors locked and they held their own keys. They also told us they would knock before entering a person's bedroom and ask their permission to clean rooms. If people did not want their room cleaned they would respect this and try again another time. We observed this happening during the inspection. A support worker also told us that people can bathe and shower whenever they liked. Those people who require assistance from staff had their own routine and staff accommodated wishes and preferences where possible. For example, one person preferred a particular support worker to assist with bathing and therefore this was arranged when that support worker was on duty.

Good

Is the service responsive?

Our findings

People and relatives told us they felt staff were "usually" responsive to their needs. One person told us that staff had recognised a skin condition and accompanied them to seek medical advice. However, their relative told us they were not happy with how long it had taken to identify the condition but confirmed medical attention was sought.

We found care plans to be person-centred. They contained information from the people using the service, relatives and external professionals which demonstrated that everybody involved in a person's care had contributed to the assessment and planning of support. There were sections such as, general details, assessments, plan, risks, evaluations and reviews, as well as information regarding medical records, mental capacity and DoLS and incidents. These were all thoroughly completed to a good standard with personalised details about each individual. For example, people's records contained a huge amount of information about their life history and the circumstances around how they came to need use of the service. This gave staff insight into people's lives and enabled them to engage better with people and be responsive to specific needs.

In order to make their care plans accessible for people, some sections were written in a way that the person would understand it. For example, the information was written in the first person, such as "I like", "I am" and "I feel". Some sections had pictures and photos enclosed to help illustrate what was being described. They also contained subsections entitled, 'All about me', 'What's important', 'How I communicate', 'What makes me happy', 'What I worry about' and 'How I like to spend my day.'

The service worked closely with external professionals and specialists and participated in regular meetings with them about people's individual needs. This ensured the staff kept abreast of best practice guidance relating to the conditions people lived with and how to manage it. It also helped staff respond to changing needs and deal with different behaviours that may have challenged them.

All people had a keyworker. This was a member of support staff who had responsibility for reviewing and updating care plans and assessments. We saw these were well organised, detailed and up to date. All of the staff were very familiar with people, their needs and their care plans and could respond to them as necessary. Staff had taken into consideration, people's likes and dislikes, preferences, abilities, routines and habits when assessing needs and developing care and support plans.

We saw the risks associated with tasks and activities were also personalised, including promoting positive risk taking. Detailed instructions were included for staff regarding precautions taken to protect people, precautions for the staff but also for instance, due to one person's complex mental health condition, precautions were also in place to protect members of the public.

The provider had recently employed a designated activities coordinator who had begun to devise a varied activities plan. Daily activities were scheduled as a guide for people and staff, however if people did not want to join in with a specific activity, staff would discuss this with them, decide on an alternative and

document this in their daily record. The information about how the person felt that day, their mood and their decision was monitored and reviewed for future planning. A recent arts and crafts session had been a particular success. One person told us, "It's the best thing I have ever done." Staff told us that other recently added activities such as papier-mâché, knitting and colouring in had been well received by everyone.

People made their own decision about which activities to take part in. The service encouraged people to engage in activities which were of interest to them. There were some activities such as parties, which were held at another of the provider's larger services which people were supported by staff to attend. We saw people went out to the local shops or café's by themselves, with relatives or sometimes accompanied by staff. We saw people independently accessing the community via public transport and taxis and we saw people going out to meet friends or had friends around to visit. The registered manager told us they preferred visitors to leave by 9PM unless with prior arrangement but there were no restrictions on bedtimes. She told us, "We do encourage people to have a routine for well-being reasons." This demonstrated that the provider and registered manager facilitated activities in order to promote inclusion and reduce social isolation.

Most people were able to make their own choices about all aspects of their life. Some people who needed help to make more complex decisions were still given choices over smaller aspects of daily living such as what clothes to wear, what to eat and how to occupy themselves. We frequently overheard staff say, "What do you want to do" and "Would you like a drink – what would you like?" One person told us, "The staff put DVD's on and we can choose what we want to watch."

The service had recorded five complaints. The registered manager told us that other minor issues had been raised, but they had been dealt with straight away in an informal manner. Most people we spoke with told us they had no complaints about the service, the staff or the provider. One relative told us, "We received information from the day centre that the home should have told us about." Another relative felt a complaint about 'missing items' had been, in their words, "played down" and not fully investigated. The registered manager assured us that all complaints were fully investigated and action had been taken to address the issues raised. A complaints log was in place and the registered manager told us the procedure was to investigate and respond to complainants as necessary. We reviewed the provider's complaints policy which had been made available to people and their relatives. The policy informed complainants of how to complain, how they would be managed and who would be informed, such as the Local Authority or the Care Quality Commission (CQC). Further details to escalate complaints were also included.

People and relatives told us they would have no hesitation in complaining and most said they felt confident that they would be dealt with appropriately. Staff also told us they felt confident to raise any complaints with the registered manager.

We read in staff meeting minutes that where minor issues had occurred the registered manager had shared these with the staff and used it as a learning opportunity. We were told that changes in practices had been a direct result of an issue being highlighted. For example, two complaints about missing laundry had resulted in people being given individual laundry baskets for their bedrooms.

We saw in care records, the service used an information sheet which could be transferred between services to enable effective communication. For example, if a person needed emergency treatment, the paperwork could be removed from the care record and be taken with the person. The document contained information about personal details, emergency contact information, health conditions and medical needs.

Requires Improvement

Is the service well-led?

Our findings

The service was operated by a team of staff. The provider and owners of the company (one of whom was the registered provider with CQC, known as the nominated individual) were more removed from the service and focused on business development and financial arrangements. An operational care director oversaw the management of this service and two of the provider's other services. The registered manager was in charge of the day to day management of the service. However, she was also in day to day charge of another of the provider's services.

The registered manager had been registered with the CQC since April 2015 to manage a regulated activity. This means she has accepted legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

The registered manager and the operational care director had extensive knowledge and experience of working with people with complex mental health needs and / or a learning disability. They were well established in their roles having originally set up the service. People were aware who they both were and knew their names. One person said, "She (registered manager) is here often but she works between two houses." During the inspection both were available and on hand to assist us with the inspection and they gave us access to the records we required.

Audits and checks were in place to monitor the quality and safety of the service. Until recently, this task had been delegated to other members of staff to undertake daily, weekly and monthly auditing of aspects of the service such as care plans, housekeeping, fire safety, kitchen safety and management records. The registered manager had not overseen these checks. We found several of the audits had not been completed for more than six months. The registered manager told us that she has been verbally assured these audits had taken place and it was with regret that she has not identified this and overseen these audits for herself. We noted that despite the lack of auditing, we found no detrimental impact on the quality and safety of the service.

Senior support staff had carried out checks of the medicine stocks and the administration records. However formal competency checks on staff's capabilities were yet to be introduced. The registered manager told us plans were in place to address this and we saw it had been discussed in a recent staff meeting. Other checks had been completed daily, weekly and monthly by senior support staff and maintenance staff, such as food, fridge and water temperatures. An infection control improvement tool has also been completed recently to identify areas for improvement. We saw new toilet brushes had been purchased following this.

Policies and procedures were reviewed; however the provider had recently invested in a new software system to produce improved versions. Access to the system was imminent which would also give them access to advice and information in order to develop the quality assurance systems already in place in order to make them more robust. We were able to review a new quality assurance tool which had been devised but not yet implemented.

Throughout the inspection and afterwards during feedback, the registered manager and operational care director were receptive of the evidence we presented to them and provided reassurances that improvements would be made. The registered manager told us she planned to relinquish her responsibilities at the other service and focus her time primarily on Manor Park in order to improve the governance of the service. The operational director told us there were plans in place to create a new post to oversee quality and compliance across the provider organisation. They were both disappointed by our findings and agreed with the lack of auditing. They acknowledged this needed to improve to give them better oversight of the service.

The culture at the service appeared to be open and transparent and the staff told us they were keen to do a good job and make it as nice as possible for the people who lived there. The staff respected the management team and told us, "I love it" and "I actually do enjoy my job." Staff told us morale was fine. One support worker said, "It's getting better and I'm feeling positive that things are improving." They explained to us that the recent staff shortages had been a difficult time.

There was a clear staffing structure in place, which included the registered manager, a deputy manager (which was currently vacant), senior support workers, support workers, domestic and maintenance staff. The staff we spoke with had a clear understanding of their role and responsibilities and were able to identify these to us. Staff could not recall having to raise a specific issue but told us they were happy to discuss any problems with the management stating, "There is always someone to go to."

Staff told us team meetings took place and we were able to review meeting minutes which demonstrated staff had the opportunity to discuss matters. Health and safety, medicine management, safeguarding, training and information about individual people's needs were regularly discussed at meetings which were held every four to six weeks. 'Resident' meetings had not been held very often. The registered manager told us, "We are very much involved with all of the time and they come to us with suggestions, such as menu ideas." The registered manager felt that due to some of the complex conditions people had, it had been difficult to hold a communal meeting.

A survey had been conducted with people who used the service in February 2016. Although it was basic, it had been produced in an easy to read format with 'smiley face' illustrations to assist people to understand it. A score process had been used to evaluate the responses and an action plan was in place to address the issues raised. The registered manager told us she had sought verbal feedback from staff and external professionals during meetings. This demonstrated that the service was actively seeking feedback from those involved in order to make improvements.

The service had developed many community links. They had links with local day services which people attended and they joined in with social occasions at one of the providers other services. The service had also forged links within their immediate neighbourhood. The registered manager told us their neighbours and some of the local businesses knew the people who used the service and they had been understanding and accommodating of the complex needs some people had.