M N P Complete Care Group

Sandgate Manor

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 15 & 16 March 2016. This service provides accommodation and care for up to 25 people with complex physical care needs. At the time of inspection there were 21 people living at the service. There were 19 people living in the main house with accommodation arranged over two floors a shaft lift provided access to the first floor. There are also three lodges in the grounds. These can accommodate up to two people in each lodge but are currently used as single accommodation there were two people living in two separate lodges at inspection and one lodge was vacant. The home is located in a residential area of Sandgate. It is within walking distance of local amenities, shops and public transport. The main town of Folkestone is nearby and can be accessed by car or public transport.

This 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.

This service was last inspected on 13 November 2014, at that time it was assessed as 'requires improvement' owing to shortfalls in: staff training records, inadequate audit processes were in place which were not effective, complaints were also not shown to be managed effectively. Since then the provider and registered manager along with senior staff have made improvements to these areas and the outstanding requirements for these shortfalls has now been met.

This inspection, however, highlighted that new quality monitoring processes are still to embed and that some minor shortfalls in operational records maintained by the service have yet to be reviewed through the quality monitoring checks made. For example some recruitment information obtained during the recruitment process had been discarded, regular fire drills were happening but monitoring of how many drills individual staff attended was not in place.

Staff were trained to meet people's needs and had opportunities to discuss their performance and work related issues during one to one meetings with their supervisor. People were safe and protected from harm because there were enough staff available to support them in the service and when out in the community, this was confirmed by people and staff and the rota reflected the staff on duty at inspection.

Staff felt listened to, supported and well informed. Several staff meetings were held each year which staff thought were enough but said the frequency of these could be increased if important information or issues needed to be discussed with the staff team.

People were encouraged by staff to make everyday decisions for themselves. Staff understood and were working to the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a framework for acting and making decisions on behalf of people who lack mental capacity to make particular decisions for

themselves. People and relatives told us they found staff approachable and felt confident of raising concerns if they had them. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

People were treated with kindness and respect; they said their needs were attended to by staff when and if they required it. People respected each other's privacy. People were supported to maintain links with the important people in their lives and relatives told us they were always consulted and kept informed of important changes.
People were well matched, they liked each other's company and being of similar ages many had shared interests. They told us they were happy there. Most had personal support hours allocated to them and chose how they utilised these hours to do the activities they wanted to do. Staff listened to what people had to say. Staff said they enjoyed working in the service and our observations showed that there was "a lot of laughter and a lot of fun", within the service.

People told us they felt safe and liked the registered manager and all the staff that supported them. Relatives told us they had no concerns about the service and were satisfied with the overall standard of support provided. They felt confident in the quality of care and said they were kept fully informed by the staff and communication was good. Professionals we contacted commented positively about the service and raised no concerns.

People's medicines were well managed by trained staff. Staff were able to demonstrate they could recognise, respond and report concerns about potential abuse. The premises were well maintained and all necessary checks tests and routine servicing of equipment and installations were carried out.

People ate a varied diet that took account of their personal food preferences. Their health and wellbeing was monitored by staff that supported them to access regular health appointments when needed. Staff understood people's individual methods of communication and how they best received information.

People were supported to develop and maximise their potential for independence at a pace to suit themselves and that they were comfortable with. Staff were guided in the support they gave to people through the development of individualised plans of care and support; risks were appropriately assessed to ensure measures implemented kept people safe.

People and relatives were routinely asked to comment about the service and their views were analysed and action taken where improvements could be made. A new quality assurance system had been implemented that looked at the self-assessment of performance with different aspects of the service, shortfalls were identified and action plans with clear timescales implemented to ensure improvements were addressed.

We have made three recommendations:

We recommend that the provider replaces personal identity information removed from staff files.

We recommend that a record is made of informal meetings and discussions with staff to inform the overall appraisal of their performance.

We recommend that the provider monitors whether all staff are participating in a minimum of two fire drills annually in accordance with recommendations for staff contained in the Regulatory Reform (Fire Safety)

Order 2005.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Recruitment procedures ensured new staff were suitable to undertake their role, but some important documentation had been discarded, and recording of staff participation in fire drills needed improving. Medicines were managed appropriately.

People were protected from harm because staff knew how to identify and respond to abuse. The premises were well maintained, and all required safety checks were in place.

Staff understood actions to take in an emergency. People were supported to take risks. Accidents and incidents were monitored and actions taken to minimise recurrence,

Is the service effective?

Good

The service was effective

Staff received appropriate induction and training to fulfil the responsibilities of their role and keep people safe.

The registered manager ensured that people were supported in line with the principles of the Mental Capacity Act 2005, peoples consent was sought by staff in respect of their care and treatment. Staff understood and supported people's communication needs.

People ate a healthy diet, maintained stable weights and their health and wellbeing was monitored by staff and some external professionals. People were supported to attend routine and specialist health appointments when necessary.

Is the service caring?

Good

The service was caring

People's privacy and dignity was respected. Staff showed kindness and thoughtfulness in their contacts and engagement with people.

Staff helped people to maintain contacts with their relatives and friends and to develop relationships with others and enable supported visits.

Relatives said they were made welcome, were consulted by staff and kept informed.

Is the service responsive?

Good

The service was responsive

People were assessed prior to coming to live in the service to ensure their needs could be met. People and their relatives were involved and consulted about care and treatment and in reviews of this.

Care and support plans guided staff to ensure care was delivered that was consistent with these. People planned their own activities for the week this enabled them to follow their interests, attend activities and events in the community and socialise and make friends.

A complaints procedure was available. Staff knew people well and gave them time to try and understand issues that affected their mood or made them unhappy. Relatives felt confident of approaching staff with any concerns they might have.

Is the service well-led?

Good

The service was not consistently well led

A new quality assurance system had been implemented to help the assessment and monitoring of service quality this was still to embed.

Staff said they felt listened to and supported and had opportunities to meet together and share issues. People staff and relatives found the provider and registered manager approachable.

People relatives and staff were routinely consulted for their views. A system was in place for the updating of policies and procedures in line with changes in legislation and guidance.

Sandgate Manor

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 15 & 16 March 2016 and was unannounced. The inspection team comprised of two inspectors.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). 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. This was completed and returned to us. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

At inspection we met and spoke with many of the people who lived in the service and observed how they interacted with each other and with staff. We observed staff carrying out their duties and how they communicated and conversed with each other and the people they supported.

We met and spoke with ten people and three visiting relatives. Not everyone we met and spoke with who lived in the service was able to speak with us so we used the Short Observational Framework for Inspection (SOFI); SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the Provider, registered manager, two deputy managers, a team leader and three other staff. After the inspection we spoke with four health professionals who visit the service who raised no concerns.

We looked at four people's care and health plans and associated risk assessments. We looked at medicine management, and a range of operational records including three staff recruitment records, records of staff meetings, residents meetings, staff training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe comments included: "I feel safe here because there are lots of people around". Another said "If there was a fire I know to go to the nearest assembly point and wait for the Fire Brigade". A health professional who visited regularly told us "I really think people are well cared for and happy, staff are receptive to what is said to them and inform us about what is going on with each person". Relatives said they thought the service provided a safe environment for their family member.

People received their medicines safely. Only staff trained in medicines management were responsible for administering medicines; they ensured people received their medicines when they needed them. Senior administering staff undertook all tasks relating to medicine ordering, receipt, storage, administration, recording and disposal in accordance with the service medicine policy. The competency of administering staff was assessed routinely to ensure good practice was maintained in accordance with medicine policies and procedures. Medicine storage and trolleys were kept clean, tidy and locked when unattended. We observed medicine administration and saw this was managed safely and that people receiving medicines were kept informed and involved in the administration process. Creams were stored separately from oral medicines. Instead of dating all medicines upon opening a running count of medicines was undertaken on a weekly basis; the registered manager and senior staff could therefore see when medicines were opened and if rates of usage were different to expected which might indicate over or under administration. Medicines with short expiry dates were dated upon opening.

Staff had received fire training, fire risk assessments were in place and all staff knew the evacuation procedure and assembly point. Individual personal evacuations plans (PEEPS) were in place for people; these took account of their specific needs and identified the method of evacuation that staff should use in an emergency. Each PEEP contained photographs of how staff should evacuate people and staff confirmed they had trained in this method at their fire drills and fire training. Regular fire drills were held which recorded the names of staff attending but there was an absence of monitoring to ensure that staff attended a drill a minimum of twice annually and this is an area for improvement.

The provider operated safe recruitment procedures. Staff recruitment records were clearly set out. This enabled the registered manager to easily see whether any further checks or documents were needed for each employee. Staff did not start work until they had attended for interview and required checks had been carried out. We checked three files two belonging to staff that had worked for the organisation for a long time and had an internal transfer to this service; we also checked the file of a staff member recruited directly by the service. Each file contained an application form with evidence of interview. Application forms contained information about people's employment histories with their reasons for leaving previous care roles where relevant, satisfactory employment and character references were obtained, a statement as to the staff member's health at the time of recruitment was also in place, a Disclosure and Barring Service (DBS) criminal record check which also checks identity was conducted for each applicant. We noted in the files viewed staff personal identity evidence used for the DBS to be carried out had not been retained. The absence of the correct information in staff members files is a breach of regulation 17 (2) (d)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff were expected to complete a probationary period before they were made permanent in their role; they met with the registered manager or deputy managers during this period so they could assure themselves that the person demonstrated the right attitudes and be confident that they had the right skills and competencies to support people safely.

There had been a large turnover of staff over the last 12 months; there was however, good retention of more experienced staff and senior staff, this provided continuity for people. People, staff and relatives told us that there were always enough staff available to provide people with the support they needed. People's needs were assessed and they were allocated hours to support their personal care and activity needs. Information gathered from these assessments informed the registered manager as to how many staff were needed to support people safely. During the daytime shifts there was a team leader and five care staff on duty. People had their own personal carers for their allocated hours of support in addition to these core staff throughout the week, during weekdays the care staff were added to by the presence of the registered manager and two deputy managers, who could be called on to for help if needed. The staff rota confirmed these levels of staffing were maintained.

Staff had received safeguarding training that helped them to understand, recognise and respond to abuse. Staff were confident of raising concerns either through the whistleblowing process, or by escalating concerns to the registered manager and provider or to outside agencies where necessary.

Risks people may be subject to from their environment or as a result of their own care or treatment needs were assessed; risk reduction measures were implemented and staff were provided with guidance on how to support people safely. Risk information was kept updated and reviewed every three months. In the event of incidents or accidents risks were re-evaluated to consider how effective risk reduction measures were or whether further amendments and changes were needed to reduce risk levels further. There was a low level of accidents and incidents reported which indicated that risks were appropriately assessed and supported. These were monitored by the registered manager and deputy managers to assess for patterns or trends which may indicate reasons for accidents/incidents occurring.

The environment was safe for people to live in. The premises were kept clean and well maintained, and all necessary checks and servicing of equipment and electrical and gas installations were undertaken. Staff reported any repairs that needed to be done into a maintenance book, there was a maintenance team that visited weekly, staff reported that repairs were usually addressed quickly and the maintenance book showed this to be the case except where other factors caused delay.

A cleaner was present onsite 9am until 5pm each day, there were three cleaners who worked to set cleaning schedules and covered the rota between them seven days per week. They had daily weekly and monthly tasks to complete to ensure that a good standard of cleanliness was maintained throughout the service. Staff were provided with protective clothing for when supporting people with personal care. An infection control audit had been introduced as part of improvements to audit processes and was to be completed on an annual basis; this audit highlighted any shortfalls in practice, or environment and actions to address these were recorded for completion within set timescales.

We have made two recommendations:

We recommend that the provider replaces personal identity information removed from staff files.

We recommend that the provider monitors whether all staff are participating in a minimum of two fire drills

annually in accordance with recommendations for staff contained in the Regulatory Reform (Fire Safety) Order 2005.

Good

Is the service effective?

Our findings

People told us that they enjoyed the variety of meals they received. Comments included "I like the food and there are good portions here. There's a list of food options in the kitchen and we write down our names. "Someone goes round and asks people what they want." "I think there should be more fruit available." "The food is OK and there's enough to eat. If I want a snack I can just ask". "I can get drinks whenever I want from the fridge or can ask staff to make a jug up. I go in to the kitchen and talk to the chef and help him with the dinner lists"
One person told us: "We have two physios who work here and they are good; they help me with exercises and stretches". Relatives said they felt that staff kept them informed about any health issues or needs their family member experienced. A health professional told us "they make appropriate referrals for equipment and have a good understanding of what people need" Another told us "The manager of other senior staff contact us frequently, they seem to spot issues quite quickly before it becomes a crisis".

New staff underwent a period of induction and were initially supernumerary on shifts for the first two weeks of their employment, this was so that they could familiarise themselves with the routines and peoples individual care regimes. The new starter induction was linked to the nationally recognised Skills for Care network and the introduction of the new Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

The provider and registered manager had undertaken to improve the way they recorded staff training to address shortfalls we identified at the previous inspection. The staff training record was now comprehensive and took account of all the training staff experienced, it showed where staff had completed their essential training and when updates were due For example, First aid, food hygiene, fire safety, infection control, moving and handling, safeguarding and mental capacity, health and safety and Medicines management for those staff that administered medicines. Staff were reminded when they needed to attend training which was classroom based and interactive, staff found that training presented in this way helped them absorb information better. Following recent staff turnover approximately one third of the staff team had completed nationally recognised vocational qualifications at level 2 and above. Opportunities to participate in vocational qualification training and career progression within the service and organisation were available if staff showed the commitment to study and progress.

The staff structure of registered manager, two deputy managers in addition to team leaders ensured that there were always senior staff available to provide support to staff and enable them to understand their roles and responsibilities. Support was provided formally and informally and this was undertaken through face to face discussion and talks with their supervisors or from direct supervisions or observations of their practice by the registered manager deputy managers and other team leader staff. Individual and group supervision was recorded, staff said that deputy managers and team leaders worked closely with them on shift and they found them easy to talk with and approachable, they felt able to approach any of the senior staff for a private talk with them if they had issues they wanted to discuss; these informal meetings were not always recorded. Staff spoken with felt the present balance of formal and informal meetings with senior staff

was about right and that they felt supported and listened to. The registered manager and deputy managers had identified this as an area for improvement and had implemented an observational tool to be used more frequently with staff to monitor areas of their practice throughout the year; this was in the early stages of use and would be reviewed to see if it was effective, we would recommend that informal discussions undertaken with staff are recorded to inform overall appraisal of performance. Annual appraisals of staff work performance were conducted and provided staff with opportunities to discuss their performance, development and training needs over the coming year.

Care staff had received awareness training of the Mental Capacity Act 2005 (MCA) and how this impacted on their everyday work. The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff assumed people had capacity and sought consent from them for their everyday care and support needs, they were keen advocates of people's rights to make their own decisions and control their lives as much as possible and the registered manager was able to demonstrate an understanding of how capacity would be assessed but recording around this was not always clear within peoples individual records. We discussed this with the registered manager as an area for improved recording.

Staff understood that for some people relatives, representatives and staff would help make more complex decisions which were beyond people's capacity to understand and that sometimes decisions needed to be made in people's best interest. The registered manager understood when a DoLS application needed to be made and was still awaiting the outcome of two referrals made. She was aware of actions to take when best interest meetings needed to be held for example, for necessary health interventions and ensured the right people were invited and involved in these discussions. Restraint was not used and staff were not trained in the use of physical interventions. Care plans were in place for people who could express strong emotions through their behaviour; this helped staff understand the behaviour and utilise simple strategies they should use to de-escalate situations and keep everyone safe.

We observed staff responding to people's different styles of communication to ensure they felt included and involved. The service was innovative in using new technology to aid people's communication skills and help them communicate with others. The service employed a communication aide who worked with people to develop photo books to record their experiences, the use of new technology was promoted for those who may benefit from this and enabled people with communication difficulties to engage and interact with a wider group of people; helped their ability to be more independent and in control of aspects of their support for example using new technology when out in the community to respond to questions asked of them, or to independently ask questions themselves or make requests.

Staff supported people with their health appointments. People were referred to health care professionals based on individual needs. Staff were vigilant in checking people's wellbeing and whether there was an emerging health related need. People were given a choice of where they received their optical, dental and chiropody care. People's weights were taken on a regular basis; these showed people maintained stable weights but where any significant loss was noted this would be alerted to senior staff. The service was fully adapted to meet peoples physical care needs, with some equipment provided by the service and other equipment funded by the person supported.

We spoke with the chef who had an understanding of people's individual dietary preferences and any specialist diets that needed to be catered for. Menus were developed from an understanding of people's likes and dislikes and feedback received directly by the chef from people or through resident feedback via staff. People had told us that that staff asked them in resident meetings what they would like to see on the menu, and we observed that people were encouraged to take their own plates back to the kitchen where

possible and spent time chatting with the chef; this gave him the opportunity to receive direct feedback from people about how they had liked their meal. Menus were on a four week cycle that took account of seasonal changes. The chef said these were suggested meals but changes could be made to them to fit in with people's personal preferences, for example someone who did not like chips might be offered mash as a preferred alternative. People had two choices of main meal and dessert, with a range of choices for the supper menu. People with specific health needs such as diabetes were supported by staff to manage their diets to make sure they were as healthy as possible. The Provider Information Return told us that no one was at risk from poor nutrition.

People who lived in the lodges said they could if they chose have meals in the main house if they wanted; one said they chose to do this at weekends sometimes for company. One person living more independently in one of the lodges said they were actively involved in shopping on line for their own food but required staff support to cook it. We observed the lunch period; the atmosphere was pleasant and relaxed. People chose to sit where they wanted their meals and for others it was a social occasion. Drinks were available. Some people required specialised support with eating their meals and had special tubes where they were fed directly into their stomach with a special liquid diet. Staff offered assistance to people who needed it by cutting up food into manageable pieces, or providing a supportive and encouraging conversation whilst assisting other people to eat their meal at a pace that suited them. Support plans for specialist eating and drinking requirements detailed for staff the process they should follow so people ate their food safely. Some people were at risk from choking and support from the Speech and Language Team (SALT) was sought to help staff manage this safely.

We recommend that a record is made of informal meetings and discussions with staff to inform the overall appraisal of their performance.

Good

Is the service caring?

Our findings

We observed that people were happy with staff, staff knew them well and there was a lot of chatter, laughter and shared experiences and comments informing their conversations. Staff were observed interacting with people in a very caring and person centred manner. Staff showed they valued people's contributions to discussions and spent time positively engaging with them.
People liked where they lived one said "If I didn't like it I would not be here." Other comments included "Staff respect our privacy and always knock on the door. They always ask before helping me or doing something". "I've lived here over a year and the people here are nice." This place is better than other places I've lived as there's always people to talk to." "The staff are really friendly and helpful and find things you ask them to do". "The staff make this a good place to live: they're really caring and really friendly". "The staff always ask me before they doing anything with me and they're really good at respecting my privacy". "When I buzz for help (on the call bell) the normal waiting time is really good. Sometimes if they're really busy and I want help I do have to wait ".
A health professional told us "Staff are very caring; they have good relationships with the people they support". Another said "The registered manager has facilitated meetings between us and the equipment repair team and when we have visited to assess peoples individual equipment they have been present and involved in discussions about what needs doing".

Staff showed they had a good rapport with people and we saw many examples of spontaneous affectionate interaction from staff towards people, for example engaging in jokey banter with some people, offering a gentle touch on someone's head or shoulder squeeze.

Staff supported people with their personal care discreetly, and people could retain their privacy by having keys to their rooms to lock them when they were out to feel confident their belongings were safe.

People were consulted about their care plans which contained information about the important people in their lives and important events they needed to be reminded about. Staff were familiar with their life stories and had built up relationships with them and their families.

Relatives said felt welcomed when they visited and were offered refreshment. People were supported to develop and maintain relationships with other people living outside of the service, and we met one person whose friend was enabled to stay over when they visited.

Staff encouraged people's independence and control over their own lives. People spoke about holidays they went on and others talked about places they liked to go in the community with staff support.

Bedrooms were of various sizes and furnished to meet the specific needs of the person living in the bedroom. People were encouraged with family or staff support to personalise their bedrooms and many seen had personal effects such as photographs, pictures, flowers, small personal possessions, and books. Some people had computers and communication aids that enabled them to independently keep in touch with friends and family, engage with others through the internet or to explore their interests. Some people

had their own televisions and this was a personal choice.

The registered manager was aware of the use of advocates for people and had used one previously to support someone with an important decision and would do so again should the need arise, no one had regular visits from an advocate and most people had relatives available to consult with if needed.

No one at the service was considered to be in need of end of life care at the time of our inspection, but the service had supported people previously to the end of their life and had knowledge and understanding of the specialist support available to ensure people received the right level of care during this time..

Good

Is the service responsive?

Our findings

When we asked people how they were involved in the planning of their care one person told us: "Yes my 1-1 hours I organise myself. I have a sheet and I write hours in and take away hours I use from the running total. When I want the support staff are willing to come before or after a shift or on a day off. My staff have become a second family: they're here for me in times of need". Other comments included "I'm involved in my care review and I feel that I am listened to". When asked about community access one person said: "I moved here a while ago now. I can go out on my own if I book a taxi and use my electric wheelchair and I like going out on day trips during the week. I go to the sports centre in Folkestone and day outings happen whenever there are enough staff." "Some of us are going to Canterbury and everyone gets asked if they want to go. I like to go out on Saturdays into town". Another said "I'm supported to be independent because staff let me do things off my own back. I can go out every day if I want to and there are also activities at the home like games, and if the weather's nice we go out and play games outside like giant snakes and ladders". Others commented "I've never had to complain but if I did I'd go to the Manager or House Manager". "I've not had to make a complaint but I know there's a procedure to go through. I've got my key worker and co key worker and could say something to them or the manager". A health professional told us "I sometimes feel people seem to sit around a lot and wonder if they should be doing more in house activities, but everyone always seems happy and I know they do go out and they do have a holiday every year".

Since the last inspection efforts had been made to ensure that complaints and concerns expressed to staff were captured and recorded and responded to. A complaints procedure was in place in a format that people could understand. We made the registered manager aware that there was an inaccuracy in the procedure and action was taken following the inspection to amend this and we received a copy of the amended procedure. The provider information return informed us that in the preceding 12 months there had been three complaints; we looked at the complaints log and noted the details of the complaints and the actions taken to address these. None had been escalated to the ombudsman or other external agency. People told us that they felt able to raise any concerns they might have with staff. Relatives said that they felt confident of raising concerns and that these would be dealt with. Two relatives said they had raised issues previously and were satisfied with the way these had been managed and addressed.

Information about people's likes and dislikes and activities that interested them were recorded in their care plans. At inspection some people were sitting around chatting or sitting companionably with others observing what was going on mainly around the reception and lounge areas, where people liked to congregate as these were hubs of activity with staff stopping to talk in passing and informal gatherings of people. Some people were engaged in personal activities such as reading a magazine; others were preparing to go out with their personal assistants. Everyone was scheduled for physiotherapy exercises in accordance with their care plan.

There were occasional resident meetings that provided people with opportunities to discuss the activities available to them and whether they wanted to change these or do additional activities. A record of the most recent meeting showed there had been a discussion about the planned holiday for the year and this had already been booked and people were travelling in two parties at different times, people were excited about

the prospect of the holiday and were happy with the people in their specific party. They looked forward to sharing this time with the staff also. People had an easy relationship with staff that gave them the confidence to approach them at any time to discuss any issue that impacted on their care and support in the service.

People did not go out every day; there were some set activities that people had in accordance with their care plan such as a physiotherapy session with the physiotherapy aide, or a hydrotherapy session which needed to be on the same day because of pressures on available slots, this was undertaken at the hospital. Outside of these times people led relaxed routines and usually went out late morning or in the afternoon if they were going out. People we met were happy with the lifestyle they led and the opportunities they had for going out, and going on holiday. Some in house activities like cooking were supported but this was dependent on people wishing to do this. No one said they were bored and we noted there was a relaxed happy atmosphere amongst people. Some people who lived in the lodges had friends who lived in the house come down to visit them during the day or in the evening. Staff took the view that everyone had the ability to make decisions about what they wanted to do and provided an individualised service to each person, sometimes if people had shared interests or were attending a shared activity, and then it made sense for them to travel together.

We met one person who had visited the service prior to coming to live there permanently; they described being visited by the registered manager and another staff member who came to meet with them to assess their needs and ensure these could be met within the service. They said they had looked at several homes but had made the decision to choose this service and were still happy with that decision. The registered manager explained that people were always assessed prior to admission and were provided with opportunities to visit if they were able, before the decision to admit them was finalised. Sometimes relatives visited on their behalf. We viewed pre- admission information for two people; this was well completed and had been developed from discussions with the person and or their relatives about their needs and how they preferred to be supported.

A care plan was developed from this that provided guidance to staff about people's daily routines; a personal profile gave staff an overview of the person's needs which included asocial history of the person and important events and work life that could be discussed with them. The care plan provided staff with an understanding of the person's communication style, any sensory needs they might have and how these needed to be supported, their emotional wellbeing, personal care and health care needs and the activities they enjoyed. This was kept under review and added to as staff became more familiar with them and their needs.

A generic template was used to record aspects of people's care, health and support needs, each was personalised to reflect the specific needs of each person and how their support was to be provided. They addressed the individual support people needed around maintaining their personal care routines for day time and night time, and showed the support people needed with social interaction and what their leisure interests were. The care plans made clear what people could do for themselves and what they needed assistance with. Each person had a key worker who took time each month to sit with the people they were the designated key worker for and talked with them about their care and support; any issues that arose from these discussions were taken forward to the registered manager or deputy manager to update the care plan.

Each person had an annual review to which relatives and care managers were invited and this looked at whether the person's needs were continuing to be met at the service and whether additional support was needed to meet changing needs. Relatives said they were able to contribute to these discussions but some

did not always attend.

People were supported with their care needs by the core staff team for the service; the majority were also allocated individual care hours each week which enabled them to utilise these hours with the support of a personal assistant; these hours could be used by people how they wished and required them to plan what they wanted to do and if they needed transport. Not everyone had the same amount of personal support hours because this was dependent on the assessment of their funding authority. People used their hours to go to places of interests outside in the community, for regular trips to the pub or shopping, or for support to attend concerts and shows. Previously personal assistants were recruited specifically to support individuals but funding arrangements by the local authority were under review in the way care support is calculated and funded, and we were informed it was likely that the personal assistant role would become more generic and used to provide support to more than one person.

People had access to transport and could book this for when they wanted to go out with their personal assistant, there were a number of vehicles of different sizes to accommodate either one or two people or for a larger party.

Good

Is the service well-led?

Our findings

People told us and showed in their interactions that they enjoyed the company of the registered manager. One person told us "I like the manager she's good to all of us; we have a laugh". Another said "We have a questionnaire every 6 months about the decoration, furniture, and our bedrooms. If I get stuck on a question the staff explain it to me". Staff said they found the registered manager approachable and spoke positively about the leadership of the service. The registered manager showed that she was familiar with individual people and their support needs, she chatted comfortably with them and people seemed pleased to speak with her.

Relatives said they found the registered manager approachable and they and staff said they felt confident that if they had any concerns these would be addressed. Relatives were happy with the service their family member received. One said they felt very lucky to have found the service and could not imagine their relative living anywhere else. They and other relatives said that they felt staff communicated what they needed to in regards to their relatives wellbeing. A health professional told us about the registered manager and staff "They are strong advocates for the people living in the service, they can be challenging and raise clinical and quality issues on behalf of service users if they feel they are not receiving the service they deserve".

Since the previous inspection there was evidence that action had been taken to improve previously identified shortfalls in records related to staff training, complaints and quality assurance and we were satisfied that this aspect of record keeping had been addressed.

The language used within records mostly reflected a positive and professional attitude towards the people supported, however, one record viewed contained task oriented language that is no longer deemed appropriate for example the record referred to staff 'feeding' a service user rather than the preferred 'assisting' the service user. A new off the shelf quality monitoring system had been purchased to enable the assessment and monitoring of all aspects of the service. The implementation of this was in the early stages. Some weekly and monthly audits for example, cleaning, catering, health and safety and medicines were completed by senior staff. The new quality system enhanced what was in place and brought this together into units that the provider and registered managers had scheduled to cover different aspects of the service over a 12 month period. The registered manager said that the provider representative took their auditing responsibilities very seriously and gave timescales for the completion of any shortfalls, which were checked at subsequent visits. Audits conducted by staff were checked by the registered manager as part of her own audit and review responsibilities, areas for improvement were highlighted with actions to be taken to address them listed. Development of the service along with others in the group were discussed at joint manager meetings.

Staff said they felt supported and listened to. The atmosphere within the service on the days of our Inspection was relaxed, open and inclusive, staff were seen to work in accordance to people's preferences and needs and their personal care support was discreet and unobtrusive.

One of the providers was present at times during the inspection and often worked shifts at the service

providing cooking support. Staff told us that the provider visited regularly and was approachable; she stopped to chat to staff and people in the service. Staff thought that communication was good; they said they were kept informed about important changes to operational matters or the support of individuals through handovers or through staff meetings, formal staff meetings were not held regularly but there had been three in the last 12 months.

Staff knew that policies and procedures were kept in the office and were aware that a new policy and procedure system had been introduced. The provider had purchased a system that ensured policies and procedures were kept updated in line with changes in legislation and guidance. There was a programme of policy and procedure update the registered manager reviewed policies to ensure these were relevant to the service or adapted them as needed.

People, their relatives and staff were asked to comment about the service each year. At the time of inspection this information was in the process of being collated. From surveys viewed comments were positive in relation to care and staff but occasional niggles with for example laundry facilities, where these were recorded there was evidence of actions taken where a specific shortfall was identified.

Since the last inspection the provider and registered manager had sourced a package of self-assessment of performance which assessed different aspects of the service over the course of the year against all the domains and key lines of enquiry. For example, infection control health and safety. Underpinning some of these assessments were other smaller audits and checks conducted on a daily, weekly and monthly basis by staff for example, cleaning schedules, medicines audit, and health and safety checks. Actions plans highlighting any identified shortfalls were developed with clear timescales for implementing improvements. The provider representative undertook monthly visits and she maintained a record of her formal visits and what she had looked at and checked any shortfalls she noted or heard about were discussed with the registered manager with whom she met regularly and action taken to address them.

The registered manager ensured that the care quality Commission was notified appropriately and in a timely manner as and when notifiable events occurred. The provider was appropriately displaying their ratings from a previous inspection in accordance with the requirements of legislation.

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 did not take formal enforcement action at this stage. 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 Important recruitment information had not been retained in staff records as required by Regulation 17 (2) (d) (i)