Turning Point

Sheldon Ridge

Inspection report

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Bradford
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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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Sheldon Ridge is located in Bierley, Bradford and provides nursing care and accommodation to 12 people who have a learning disability and complex needs. Accommodation is split into two ground floor units each containing six single occupancy bedrooms. Each unit has its own dining and living areas. To the exterior of the building is a communal garden.

The inspection was unannounced and took place on 14 and 15 December 2015.

A registered manager was in place. 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. The registered manager was responsible for the strategic oversight of the home, with a home manager in post, who was responsible for the day to day running of the home.

People who used the service were unable to verbally communicate with us, however we extensively observed care and support including people's gestures and body language. We observed kind and caring interactions between staff and people who used the service. People appeared comfortable and relaxed in the company of staff and staff understood people's individual methods of communication.

Relatives told us that people using the service were safe and did not raise any concerns with us.
Staff had a good understanding of how to identify and act on allegations of abuse and we saw examples where action had been taken following incidents to keep people safe.

Medicines were safely managed. People received their medicines as prescribed and at times that met their individual needs.

There were sufficient numbers of staff deploy to ensure safe care and support. Staff were safely recruited to help ensure they were of suitable character to work with vulnerable people.

The service adopted a personalised approach to risk management. Risks to each individual were thoroughly assessed by the service and a highly individualised plan of support put in place to help keep people safe.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA).

People were supported appropriately to eat and drink and maintain good nutrition. People's weights were regularly monitored and health professional input sought where risks were identified.

Staff received a range of training which was kept up-to-date. Staff we spoke with demonstrated a good

understanding of the people and topics we asked them about indicating this training had been effective.

Relatives we spoke with said staff were kind and caring and praised the high level of attention to detail and personalised support provided by the service. Relatives told us staff had gone the extra mile in ensuring individualised support and activities were provided to people. Staff displayed an excellent understanding of the people they were caring for and a motivation and passion to providing a caring service.

The service had put considerable time and resources into providing creative care solutions to identified problems such as privacy, dignity and distress. We saw these had been effective in improving people's care and support outcomes.

People's needs were fully assessed and a range of care plans put in place. Staff we spoke with were knowledgeable about people's plans of care and we saw examples of these plans being followed.

A range of activities were provided to people which met their individual needs. We found documentation of the activities people had been involved in was not consistently in place, although plans were in place to address.

The service had not reported all statutory notifications to the Commission as it had not notified us of all safeguarding referrals made to the local authority.

A range of audits and checks were undertaken by the service to monitor , and improve the service. We saw evidence these were identifying and rectifying issues. However there was a lack of accountability for some boxed medication as stock levels were not routinely monitored.
Relatives and staff spoke positively about the home manager and said they were effective in dealing with any concerns or queries. Staff reported that morale was good.

The home manager demonstrated a commitment to continuous improvement the service. A number of initiatives were planned to further improve the service over the next year.

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.

Staff adopted personalised and creative methods to manage risks and help ensure people's safety.

Medicines were safely managed and people received their medicines as prescribed.

Sufficient numbers of staff were deployed and safe recruitment practices were in place to help ensure staff were of suitable character to care for vulnerable persons.

Is the service effective?

Good

The service was effective.

Staff received a range of relevant training on induction and at regular intervals. Staff we spoke with demonstrated a good knowledge of the people and subjects we asked them about.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards(DoLS). Where people lacked capacity, the correct best interest process was followed.

The service assessed people's healthcare needs and ensured regular liaison with health professionals to ensure people's needs were met.

Is the service caring?

Outstanding

The service was very caring.

Relatives told us staff were exceptionally kind and caring. Staff had developed strong relationships with the people they were caring for. We saw examples of staff putting exceptional thought into ensuring people were treated with dignity and respect and in ensuring they received highly personalised care.

Creative methods were used to allow people to express their views.

Is the service responsive?

Good

The service was responsive.

We saw the service had spent time ensuring people received personalised care and support and saw evidence of positive outcomes for people that used the service.

Mechanisms were in place to involve people and their relatives in decisions regarding their care and support.

People undertake a variety of activities, however this was not always robustly documented.

Is the service well-led?

Requires Improvement

The service was not consistently well led as the service had not submitted all required notifications to the Commission.

People and staff spoke positively about the way the service was run.

A range of audits and checks were undertaken to continuously monitor and improve the service and people were regularly asked for their views on the service.

Sheldon Ridge

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 14 and 15 December 2015 and was unannounced. The inspection team consisted of one inspector and an 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, in this case experiences of services for people with learning disabilities.

We used a number of different methods to help us understand the experiences of people who used the service. As people who used the service could not verbally communicate with us, we extensively observed care and support and people's body language. We spoke with four relatives of people who used the service, five support workers, the home manager, and two registered nurses.

We looked at three people's care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority contracts and safeguarding teams.

We also spoke with three health and social care professionals who regularly worked with the service.

Good

Is the service safe?

Our findings

Although people who used the service could not verbally communicate with us, we observed their body language and gestures. We noted people looked comfortable and content in the company of staff. Relatives we spoke with told us they thought people were safe living in the home. They told us they hadn't seen anything of concern during their visits to the home.

Staff had a good understanding of how to identify and act on allegations of abuse. We saw examples of where concerns had been identified and promptly reported to the home manager. These were appropriately investigated by the home manager to help keep people safe. Where necessary, disciplinary processes had been followed. This demonstrated the correct procedures had been followed to help keep people safe.

Comprehensive risk assessments were in place for each person who lived at the home. This included assessing a range of potential hazards to each individual such as, the risk of abuse, social isolation, diet and nutrition and any risks associated with medical conditions such as epilepsy. When people were supported in the community, detailed risk assessments were in place covering possible hazards which could present during these trips out. These provided staff with clear information on how to keep people safe.

Staff and the home manager had a good understanding of the risks presented to each individual and how to effectively control them. Where risks such as behaviours that challenge others presented we saw staff were quick to respond and intervene to keep people living in the home safe. The service had developed a creative and person centred approach to risk management to help keep people safe. For example one person had experienced a number of falls whilst in their bedroom at night. Staff had subsequently attended training on falls prevention which enabled the service to think about a range of possibilities to improve the person's safety. Adaptions were then made to the person's furniture to remove sharp edges to reduce the impact of falls and a multi-disciplinary meeting was set up, involving a psychiatrist, a specialist nurse, a doctor, a pharmacist and the person's relative. Following this meeting, the service obtained a bespoke enclosed bed for the person and since its installation the person had not fallen. This demonstrated an effective approach to risk management.

Adaptions to the building and garden areas had been made to control risks so that people could live as full a life as possible. For example one person who used the service had a tendency to eat vegetation growing in the garden. One staff member had taken the lead to champion an initiative to remove all non-edible vegetation from the garden and replace with edible plants such as herbs so that the person could enjoy the garden without risk, or the need for constant supervision or control.

Staffing levels within the home were carefully planned, with colour coded rotas used to allocate staff to each of the two bungalows, activities or to one to one support packages. The home manager told us that safe staffing levels consisted of one registered nurse on duty at all times and three support workers in each bungalow. In addition, staff were allocated to provide activities and undertake one to one support. We found these staffing levels were sufficient to ensure people received safe care and person centred support.

During observations of care, staff were always supervising communal areas and able to intervene promptly should people become distressed or require personal care.

Relatives we spoke with told us the home operated with enough staff. Staff we spoke with said that most of the time there were enough staff, but that there were occasions when people rang in sick which left the home short which meant sometimes people did not receive their one to one support. However no staff reported any safety concerns regarding staffing levels. Bank staff were available to cover absences, with a low number of agency staff utilised.

We found medicines to be safely managed. Medicines were administered by trained nurses and periodic checks were undertaken on their competency to ensure they had sufficient knowledge to safely administer medicines.

Well understood arrangements were in place to ensure people who needed medicines to be administered at specific times got them at right times, for example medicines needed to be given before or after breakfast.

Systems were in place to order, and dispose of medicines. Medicines were well organised and stored securely.

Where medicines were administered from a pre-packaged box, we saw the nurse carefully checked the medicines against what was prescribed to ensure they had been packaged correctly by the pharmacy. Where bottles of medicines were in use, the date of opening was written on the side of the bottle by nursing staff to ensure its expiry date was known.

We looked at medication administration records and saw these were well completed, showing people received their medicines as prescribed. Stock levels of "as required" medicines were routinely monitored to check for any discrepancies.

Arrangements were in place to ensure the application of topical creams. Body maps were in place which provided clear instruction to support workers on where and when to apply creams. In order to promote the consistent application of creams, each person's toiletry bag had a tag with clear instructions of the creams that needed to be applied. This reminded support workers to apply these after bathing and showering. The nurse on duty was responsible for checking that support workers were applying these creams correctly.

Although some "as required" protocols were in place, detailing when people should receive these types of medicines this was not consistently the case. Nursing staff we spoke with demonstrated a good understanding of when to administer these medicines, however in the absence of clear protocols defining exactly when to offer "as required medicines" there was a risk that staff would not consistently administer to the same criteria. More well defined strategies could also have been recorded to help reduce use of 'as required' medication to control behaviours.

Some people took medicines that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked and signed by two appropriately trained staff

The premises was divided into two bungalows each with six service users. There were sufficient communal areas which included a dining room and lounge in each unit. There were adequate toilet and bathroom facilities. The premises were sufficiently maintained and we did not identify any hazards or risks to people's safety. Doors to kitchens and offices were kept secure with keypad locks. Objects which could be thrown or

posed a safety risk had been moved, however despite this the home did not feel institutional, it was nicely decorated and there were lots of Christmas decorations in place which made it feel homely.
We looked at documentation which showed regular maintenance checks such as fire, gas and water systems were undertaken to help keep the building and people safe. People had personal evacuation plans in place which detailed what to do if there was a fire and considered their individual needs and presentations. Checks on equipment such as mattresses and hoists took place to help ensure they were kept in a safe condition.

Safe recruitment procedures were in place. This included ensuring people completed an application form detailing their previous employment and qualifications. A thorough selection process was in place which included a telephone interview and candidates were then invited to face to face interviews which included meeting people who used the service to determine whether they interacted appropriately with them. Sufficient checks on people's backgrounds took place including ensuring a Disclosure and Barring Service (DBS) check and references were undertaken Staff we spoke with confirmed that when they were recruited the required checks had been undertaken. A system was in place to monitor each nurse's professional registration to ensure they did not elapse.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of
their liberty.

Due to the level of constant supervision and control exercised over all people who used the service, the home manager had put DoLS applications in for all 12 people who lived at the home. Our scrutiny of people's care records demonstrated that all relevant documentation had been completed. A number of applications had been approved, whilst for others the service was waiting for assessment by the local authority. Where DoLS had been approved staff understood how to work within the authorisations to ensure people's rights were protected and minimise restrictions. When DoLS had expired additional applications had been made by the home manager.

Where DoLS were in place care plans created by the service, considered the least restrictive options to help protect people's freedom and rights. The home manager demonstrated a good understanding of the safe application of DoLS which gave us assurance that the correct processes would continue to be followed.

We checked whether the service was working within the wider framework of the MCA. Where people lacked capacity to make specific decisions mental capacity assessments were in place. Where decisions needed to be made, these had been conducted as part of a best interest process. For example we saw how the correct process had been followed to get one person a specialised bed.

People were supported appropriately to maintain good diet and nutrition. A varied weekly menu was in place which varied over a three week cycle and was adapted to the season. Staff and the home manager told us the menu was developed with people who used the service to ensure it met people's individual preferences. The chef told us that there was nobody living at the service with particular requirements due to culture or religion however arrangements were in place to provide cultural sensitive food if required. If people didn't like the food on offer, arrangements to provide in alterative were in place.

We observed care and support and saw people were supported appropriately at mealtimes and to be as independent as possible. Plate guards were utilised to reduce the risk of spillage. There was a supply of clean tabards to protect people's clothes.

Nutritional care plans were in place and these were detailed and person centred for example they provided clear instructions on how to fortify foods to ensure sufficient nutrition. Clear instructions were in place regarding the consistency of food required and whether liquids needed to be thickened to ensure safe care. We found staff were able to confidently describe who required their food to be of a certain consistency and who required thickening fluids demonstrating care plans were well understood. Liaison took place with speech and language therapists to ensure professional advice was sought on thickened fluids and consistency of foods.

People's weight was regularly monitored by the service. Where people had lost weight, we saw they had been appropriately referred to the dietician and nutritional supplements were prescribed. A relative told us that their relative was 'very picky about food' and said the service had referred them to a dietician and they now provided nutritional drinks. People's food and fluid intake was also monitored where they were deemed at risk. We looked at one person's charts and saw they were well completed, although there was no overall evaluation of the charts to determine whether they were eating sufficient quantities over a period of time.

People's healthcare needs were thoroughly assessed by the service. Health related care plans were completed by registered nurses and detailed people's health conditions and how to effectively support them. Each person who used the service had a clear health action plan in place. A Health Action Plan is a personal plan about what people with learning disabilities need to do to stay healthy. It lists any help that they might need in order to stay healthy and makes it clear about what support they might need. These contained clear actions and responsibilities to ensure people's health was effectively maintained. These were generally up-to-date although we did identify one person's was overdue a review. The home manager had recognised some care plan documentation needed updating and was working their way through these tasks. A schedule of health appointments was in place for each person and we saw evidence that people received an annual health check-up.

Hospital passports were in place. A hospital passport contains key information about the person's needs to ensure effective care and support should they be admitted to hospital.

There was evidence of liaison with external health professionals and their advice recorded in care files for example the epilepsy nurse, speech and language specialists and health facilitation nurses. Relatives we spoke with told us they thought people's healthcare needs were met by the service. One relative told us how they thought the service had really improved over the last few years and any pain/discomfort was now promptly identified through staff being vigilant for changes in behaviour. Health professionals we spoke with generally told us the service provided effective care, liaised appropriately with them and listened to their advice.

We looked in the bedroom of one person who had been diagnosed with autism. Through research of the person's behaviours, the service had identified that the use of visual stimulation would help comfort the person. They had had taken measures to adapt their room, providing a visual experience through the use of lights and lamps.

We saw examples of the building and premises being adapted to help ensure effective care which met people's individual needs. For example, a specialist all in one bed had been made for one person, where the mattress was integrated into the bed, as they had previously had a habit of throwing the mattress on the floor. Care had been taken to ensure the materials used were suitable and did not distress the person. A relative told us that they had been at meetings where the staff were always willing to change furniture or furnishings in rooms to suit individual requirements.

The home manager had identified that some aspects of the premises were not ideal in terms of space and organisation for delivering effective care and was looking at a plan to further develop the building in the future.

Relatives we spoke with said staff had the correct skills and knowledge to care for their relatives. Comprehensive face to face induction training was provided. This covered core mandatory subjects including manual handling and safeguarding. We saw new staff without previous care experience were supported to complete the Care Certificate.

We looked at the provider's training matrix. This showed people received regular training updates in subjects such as medication, positive behaviour management, first aid and support planning . Mandatory training was all up-to-date in the required subjects.

Specialist training had been provided to some staff, for example intense interaction training. More intensive training in DoLS/MCA had also been provided to some staff and further staff were booked on this course.

Staff received regular supervision and annual appraisal. Staff told us they felt well supported in their role.

Plans were in place to develop training and support further. For example plans were in place to introduce "champions" for certain topics, this would mean a named staff member would be responsible for promoting key topics. Plans were also in place to introduce clinical supervision for nursing staff as the home manager had recognised that this was a gap in staff support.

We spoke with a relative who told us they had volunteered to be part of the induction training team. They spoke to new recruits to explain the parental point of view – what it's like to have a son or daughter needing support. The home manager told us how this had been a really positive contribution, and had allowed the service to reflect on the individuals and relatives points of views, to ensure more person centred and individualised care.

Where people displayed behaviours that challenge others we saw these were dealt with confidently by staff. Staff were diligent to reduce any distress between people who used the service. Staff were aware of the techniques to use with each individual who used the service and we saw these were confidently applied. For example we saw one person trying to put on another person's coat. Staff dealt with this quickly, explaining that it was someone else's and distracting the person so the situation didn't escalate. We saw that following a bereavement, another person had been supported appropriately to meet a psychologist. Arrangements were in place to allow this person to have short breaks, sometimes a couple of hours, sometimes longer, by going to visit another service run by the provider to help reduce anxiety and distress.

Outstanding ☆

Is the service caring?

Our findings

All the relatives we spoke with told us staff were kind and caring and treated people with a high level of dignity and respect. One relative told us, "I'm really happy with the people. [the nurse] has a lot of time for my relative and [the key worker] loves her. I believe she's really well cared for.' Another relative told us, "The staff are very, very caring." A third relative told us "[person] is so unbelievably happy around [staff member]. They have taken the time to understand her." They went on to describe how staff had gone above and beyond their duties in caring for them and ensuring a high level of attention to detail. Relatives remarked how both the nurses and home manager truly cared about people and took the time to interact with them regularly as well as completing management and documentation tasks.

Although nobody who lived at the service could express their views verbally, the service used individual ways to help people to express their views and understand things from their point of view. An involvement charter was in place setting out a strategy for involving people in the service. This included promoting decision making, communication, dreams and aspirations. Each month, there was a focus on one of these subjects to ensure people were routinely involved in care and support. We were shown an example from the previous month where the service had worked with a person to obtain their views over the suitability of a respite placement at another service. The aim was to help determine whether this service was right for them or whether they needed to spend time in a quieter environment. Although the person could not communicate verbally, staff had spent time observing the person's non-verbal communication and interaction with others in this respite environment to assess their views and preferences over the suitability of this location as a short break destination.

People who used the service were also encouraged to express their views through the People's Parliament run by the provider. Each month representatives from the service attended the Parliament where they were involved in making decisions about care and support and campaigning for better rights for people with learning disabilities. For example in 2015 they had been involved in a campaign to reduce taxi fares for disabled people in the Bradford area.

The service took the time to teach people about other cultures and ways of life through events such as African and American themed days which consisted of activities, dress and cuisine of the culture or country. As well as a successful way to promote different cultures with people they were used as a creative platform to trial foods and determine people's culinary preferences. This was then used to inform future menus.

In other examples staff had considered and altered the textures of materials present within people's rooms, the level of visual stimulation present and vegetation type within the garden in order to provide a highly individualised environment which met people's individual needs.

During observations of care we saw that staff treated people very respectfully. For example, we saw a member of staff say to a person that they were going to wipe their mouth, and then their hands, before doing it. Afterwards, they said 'thank you' to the person. We observed staff interacted positively both verbally and through the use of body language and gestation adapted to the person's needs. For example a member

of staff put an arm round someone's shoulders in a gesture of affection. The member of staff held this person's hand to lead them to use the toilet – as the person was visually impaired. We saw people looked clean and tidy and were well dressed, indicating their personal care needs were met by the service.

Staff were highly attentive to people and their individual needs. For example at lunch time, we saw a person take off their tabard after their meal. A member of staff then brought them a cup of coffee and got another, clean tabard for this person, who was able to drink the coffee independently without spilling on their clothes. We saw that another member of staff was observant and responsive to people's needs noticing that one person's shoe laces had come undone and did them up for them. The staff member spoke to the person before helping them, saying what had happened and what they were going to do. During one to one support we observed staff made an effort to engage and comfort people, for example complimenting them on their appearance and stroking their hair. Staff spent time constructively for example taking the effort to regularly guide people into different rooms within the home to experience different environments. People looked comfortable in the company of the staff who were supporting them.

We saw the staff responded rapidly and effectively to ensure people's privacy was maintained. At one point, one person was in the toilet and the door opened; a member of staff immediately noticed and closed the door to preserve this person's dignity. A member of staff told us about one person who used to display distress behaviours in front of the lounge windows and in their bedroom which had resulted in a loss of dignity and privacy. The service had observed the person and their reactions and established the cause of the behaviour was particular textures of fabric on the curtains and clothes in their home which caused distress. The service had removed all curtains from the lounge and bedroom and replaced with frosted glass and roller blinds to maintain privacy. They had converted part of a bathroom into a specialist wardrobe to allow the person to store their clothes away from their bedroom. This had resulted in an improvement in their behaviour and less distress and anxiety. The staff member we discussed this with demonstrated a caring and person centred approach telling us, "It's about what the person wants and, after all, they are paying the rent to live here."

Staff spoke confidently and passionately about these measures put in place to support people. It was clear there was genuine motivation for ensuring people were well cared for.

Staffing arrangements were flexible in ensuring that the care and dignity of people was thoroughly planned for. For example in supporting one person to go swimming it was deemed through a best interest process that swimming activities should take place later in the evening when the pool was quieter to reduce their anxiety and preserve dignity and privacy.

Staff had time to spend with people and develop strong relationships with them. Staff knew and understand people as individuals with their own needs and preferences. For example, a member of staff was able to tell us in detail about how one person liked to be supported with their morning and breakfast regime. At lunchtime, we sat with a person who banged the table quite loudly with the flat of her hand. A care worker knew straight away that this person was simply saying they were ready for their lunch.

Care plans contained clear details on people's likes, dislikes and how they wanted their care to be delivered. This showed a person centred and inclusive approach to care. The gender of care was considered in the provision of care and support. Clear plans were in place to support staff to communicate with people. Staff we spoke with had an excellent understanding of how to communicate effectively with them and we saw examples of care plans being followed.

People's independence was promoted. Daily spot goals were in place for each person with the aim of

increasing people's independence. These were regularly reviewed and we saw examples of people achieving these goals.

Advocacy services were available and we saw evidence the service had liaised with advocates as part of a multi-disciplinary team.

Relatives told us the home genuinely cared about people, listened to them and acted on any their comments and suggestions. For example one relative told us how the service had gone the extra mile to plan and deliver a special birthday party for their relative. The service had met with them, asked them what type of event they wanted and then planned and delivered a bespoke event around their preferences. Another relative told us the service always took the time to ensure people's birthdays were made a special event for them. Relatives could visit the service whenever they wanted and they reported no restrictions on visiting. Relatives said they were fully consulted in decision making processes for example around the introduction of new equipment and other initiatives suggested by the home to improve people's dignity, care and support outcomes.

Where appropriate end of life care plans were in place. A relative told me they had been invited to the service to take part in an End of Life plan for her relative. They told us it had been done in a private and sensitive way. An external health professional who specialises in End of Life care, told us the service had liaised with them appropriately and demonstrated a good level of innovation in helping to plan individualised end of life care.

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Good

Is the service responsive?

Our findings

Relatives we spoke with all praised the care and support provided by the service. They all gave examples of where personalised care and support had been provided to their relatives and said their relative's needs were well understood by staff.

People's needs were assessed and person centred care plans put in place for staff to follow. We looked at care records. These contained detailed information about what was important to the person, for example what makes them sad, bored and detailed information on their character and personality. Care plans were in place which covered areas such as continence, eating and drinking, night support, falls and moving and handling. They showed people's needs had been thoroughly assessed as part of a plan to provide personalised care and support. Some care plans required updating, we saw the home manager was working through documentation to ensure it was up-to-date and relevant.

Care plans contained a circle of support for each person which detailed the people important to them and who should be involved during care plan development and review. People's spiritual and any cultural needs were considered as part of the care planning process.

A strong and person centred approach was in place to ensure highly individualised care and support. One person who used the service had displayed distress behaviour particularly during mealtimes. The service undertook detailed research to understand the situation from the person's point of view. They concluded the person needed to feel secure, and not exposed whilst sat down. The service worked with the Occupational Therapist to provide a bespoke enclosed dining table for the person, placed away from the noisier parts of the dining room. This had been successful in reducing the person's distress. Staff had then taken the effort to replicate this arrangement in the family home so the person could visit without becoming distressed. This had allowed the person to successfully visit their family home for the first time in several years.

Staff we spoke with demonstrated an in-depth knowledge of the people they were caring for and how to interpret their body language. We saw staff using care and support techniques displayed in people's care plans showing they had a good understanding of how to care for people.

Where people had been involved in safety related incidents such as falls, creative and person centred solutions were put in place demonstrated a high level of personalised care. For example a bespoke bed and furniture had been manufactured in response to a number of falls. We saw this had been success in reducing incidents. The person's relatives told us they were involved through the whole process and felt the bed was a great success.

Daily handovers took place to inform staff of any changes in people's needs. A well organised board was in place which detailed the care and support required each day, this helped ensure people received planned activities and attended appointments as required and helped achieve responsive care.

The home manager had recently introduced "spot goals", to help support people develop skills for themselves, for example in assisting with laundry or becoming more independent with eating and drinking. Staff supported people to achieve these goals on a daily basis. These were evaluated at the end of the month. We thought more could have been done to document the development of people who used the service. For example although one person had a housing plan for independence there were no timescales or measurable steps to achieve these goals.

Staff rotas were adapted around this need with shift patterns changed, showing a person centred approach. We saw other examples, where staff working hours had been changed for the benefit of people who used the service, for example, it was agreed that two shorter one to one support sessions were in the best interest of one person who used the service to alleviate anxiety. This arrangement involved the staff member having a break from paid work for several hours in the middle of the day between shifts, however this had benefited the person who used the service

Staff were employed to specifically engage in activities and events with people and take them out into the community. For example on the first day of the inspection, staff were able to support one person to take their Christmas presents home to their family. Activities planners were in place which were organised so that everyone got to do something each day. On the second day of the inspection we saw a Christmas party took place which was well received and attended by people and their relatives. Staff told us that people go out frequently for example pub lunches, walks and to the park. A range of planned events too place such as trips to Blackpool to see the illuminations and Christmas shopping. However records of past activities were not always fully completed, and we were therefore unable to robustly evidence the activities people had been involved in. The home manager had recognised this was an area for improvement and set up a working group to address.

A system was in place to record and investigate complaints. Information was clearly displayed within the home to bring the procedure to the attention of people who used the service and their relatives. We saw both informal verbal and formal written complaints were recorded. Records showed that where complaints had been received they had been investigated and responded to. Relatives we spoke with told us they were happy with the service and had few complaints at the present time. One relative told us how the service had significantly improved over the last 18 months and the current home manager was responsive in dealing with any issues that arose. Another relative told us 'any complaints are dealt with promptly.'

We saw action was taken to improve the service. For example there was a complaint about the appearance of meals. Additional training had been provided to staff with regards to how to ensure food looked presentable and appetising.

Requires Improvement

Is the service well-led?

Our findings

We found the provider had not submitted all required notifications to the Commission. We saw a number of safeguarding referrals had been made to the local authority for example in November and December 2015. Although we were satisfied that appropriate action was taken to investigate and keep people safe, these incidents had not been reported to the Commission which is a legal requirement. This meant we did not have accurate information on the number of safeguarding incidents which occurred in the service. We warned the home manager of the need to ensure all notifications were reported to us in the future.

We found some documentation relating to the management of the service such as recruitment records should have been better organised. We saw evidence the home manager was in a transitional phase sorting and organising documentation to ensure it was consistently in place which provided us with assurance that this would be effectively actioned.

Although systems were in place to ensure stock levels of "as required" medicines were robustly monitored, they were not for other boxed medicines which people were prescribed. The home manager agreed to take immediate action to ensure these were put in place.

We observed a pleasant atmosphere within the home with people and staff getting on well and friendly and meaningful interaction taking place.

Relatives we spoke with told us the service provided high quality care and support. For example one person told us "Things are going great. I have every praise for them." Another relative told us, "Past two years best ever been . [home managers name] is good at both the nurse and manager role."

The staff we spoke with said staff morale was good. All the staff we spoke with told us the home manager did a good job. Staff praised the home manager's person centred approach to care and support and said people's outcomes had improved under their leadership. One staff member told us of the home manager "brilliant , supportive, manager is there when you need here, she does listen." Staff demonstrated to us they were committed and motivated to providing high quality and person centred care.

We saw the home manager had recently won an internal award for reduced agency use. They had requested that the staff team be rewarded for their hard work and reduced absences which had made the reward possible. This showed that the home manager recognised the importance of teamwork and the role of the staff in attaining achievements.

The home manager had a good understanding of the service and we saw they were committed to further improvement of the service. For example a new staff group of eight people has been set up to co-ordinate activities and make sure they were properly recorded in people's care plans, as they had identified that care records did not reflect the variety and number of activities that people were involved in. We saw this was having a positive effect on the way activities were recorded.

The service promoted the involvement of people and their relatives in the running of the service in a number of ways. The provider ran a 'People's Parliament', where two people from the service periodically attended. These people represented the service and helped involve people in the running of the service. Quarterly parent and carer meetings also took place. These were an opportunity for people's relatives to be involved in decisions relating to the service and discuss topics such as activities. People's relatives were also periodically asked for their views on the service through an annual satisfaction service. We looked at the most recent audit which showed a high level of satisfaction with the service.

Regular staff meetings took place, this included support staff meetings and chef meetings. We saw people's individual needs were discussed and other topics such as food and activities.

Systems were in place to assess and monitor the quality of the service. A range of audits were undertaken. For example both internal and external medication audits were undertaken, we saw evidence these had identified and made improvements. The home manager conducted care plan audits, although there was not always a clear action plan in place to detail the improvements required. Audits in infection control, recruitment, health and safety and finances took place
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The home manager completed an annual self-assessment audit based on the CQC five domains. We saw evidence this had identified issues and plans were being developed to address these. For example we saw the building layout was one area that the service wanted to develop to ensure it was better adapted to meeting people's individual needs

The home manager undertook spot checks of care quality at random days and times. This was to help ensure people were receiving appropriate support in their absence for example with regards to enabling activities.

Periodic audits were carried out by head office. We looked at a recent audit completed in August 2015 and saw that a number of actions had been generated. We saw the home manager had signed off the actions these off when complete as part of a system to continuously monitor and improve the service.

An electronic incident monitoring system was in place. We saw evidence that incidents had been logged on this system. Actions were in place following incidents to reduce the risk of re-occurrence. When we asked about particular safety incidents the home manager was able to give us a good account of how the risk had been reduced which gave us assurances that lessons had been learnt to help improve safety.