Leonard Cheshire Disability

Appley Cliff - Care Home Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 15 May 2018 and was unannounced.

Appley Cliff is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Appley Cliff is a care service which provides accommodation for up to 13 people who have a physical disability. At the time of our inspection there were 12 people living at the service.

There was a registered manager at the service. 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 last comprehensive inspection of this service was in May 2016 when the service was rated 'Good'. At this comprehensive inspection, we found the service was not meeting all the legal requirements and was rated 'Requires Improvement'.

When we completed our previous inspection on 10 May 2016, we found concerns relating to the management and recording of topical creams, and gaps in the previous employment of staff. At this inspection, we found that these specific issues had been addressed, however we identified other concerns over the safe storage of people's medicines.

People were not always treated in a kind and caring manner. We observed some interactions between people and staff, which did not respect people's dignity.

Quality assurance systems were not always robust enough to identify and monitor some environment risks, and risks to people. These had not been used effectively to identify concerns we found during the inspection, or drive improvement in the service.

Although people's bedrooms were decorated to each individual's taste and contained personal possessions and photos, we identified certain areas of the service were in need of refurbishment and redecoration. Some areas of the service posed a risk of infection and contamination due to ineffective cleaning on damaged surfaces and areas.

People's care plans contained individual information, however some areas did not always reflect people's needs.

People felt safe at the service and staff were aware of their responsibilities to identify, prevent and report

abuse. People's rights were respected and the principles of the Mental Capacity Act 2005 were being followed appropriately.

People were encouraged to make decisions about how their care was provided, and staff encouraged people to be as independent as possible in their day to day lives.

Effective recruitment procedures were in place, and there were enough staff available to meet people's needs.

Staff received regular and meaningful supervision and staff had an opportunity to voice their individual views.

Plans were in place to deal with foreseeable emergencies such as fire risk; staff we spoke with said they had had received training to manage such situations safely.

People were supported to maintain their health and well-being. Staff supported people to attend appointments with healthcare professionals. People were encouraged to eat healthily and staff made sure people had enough to eat and drink.

There was a complaints policy in place and people felt able to raise concerns.

There was an open and transparent culture. Visitors were welcomed and the registered manager sought and acted on feedback from people.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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 always safe.

People's medicines were not always stored securely and risk assessments had not been completed to manage this.

Equipment used by the service to mitigate certain risks to people was not always used safely.

A number of areas of the service could not be cleaned effectively, which posed a risk of infection.

People said they felt safe and staff understood their safeguarding responsibilities.

There were sufficient staff to meet people's needs and appropriate recruitment procedures were in place.

Is the service effective?

Good

The service was effective.

People's needs were met by skilled staff who were supported appropriately in their roles.

People were supported to access health service and attend appointments

Staff followed legislation designed to protect people's rights and freedom and had understanding of The Mental Capacity Act.

The environment was supportive of people who lived there, however some areas were in need of redecoration and refurbishment.

People had enough to eat and drink and were offered a choice at meal times.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed some interactions between people and staff which did not always value people as individuals.

Staff protected people's privacy and encouraged people to maintain their independence, however people's dignity was not always considered in relation to the service environment.

Staff knew what mattered to people and had developed close relationships with them.

Is the service responsive?

Good

The service was responsive.

Information in people's care plans was not always reflective of their current needs. However, staff knew people well and demonstrated an in-depth knowledge of their individual needs.

There was a complaints procedure in place and people felt able to raise concerns.

People were supported to access a range of activities and events, and were encouraged to socialise.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A quality assurance process was in place; however, this had not identified all the areas of concerns we found during this inspection.

People and their relatives felt the service was good, and were asked for their views about the service by the registered manager.

The provider supported the registered manager to enable them to manage the service effectively.

There was an open culture within the service and staff told us they felt able to raise concerns.

The policies we looked at during the inspection were appropriate for the type of service.

Appley Cliff - Care Home Physical Disabilities

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 May 2018 and was completed by two inspectors and an inspection manager.

The service was last inspected in May 2016 when the service was rated 'Good' overall. At this comprehensive inspection, we found the service was not meeting legal requirements and was rated 'Requires Improvement'.

Before the inspection, the provider completed 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 any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

We spoke with eight people living at Appley Cliff. We also spoke the registered manager, the activities co-ordinator, four care staff, a housekeeper and a cook. We looked at care plans and associated records for seven people, staff duty records, three staff recruitment files, records of accidents and incidents, policies and procedures and quality assurance records. We also spent time observing the care and support people received in communal areas of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Following the inspection, we received feedback from one social care professional, who had contact with the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2016, we identified that prescribed topical creams were not managed safely. We made a recommendation for the service to consider current guidance on the management of prescribed topical creams, and implement action to update their practice accordingly. At this inspection, we found that action had been taken and systems were in place to ensure that prescribed topical creams were applied correctly and managed safely in accordance with the manufacturer's guidance.

People were supported to receive their medicines safely and as prescribed. One person told us, "The staff sort my medicines, they never forget." Another person said, "If I ask for something for a headache, I can get it."

One person was self-administering their medicines and a risk assessment which involving the person, had been completed. This risk assessment stated that staff were responsible for ordering medicines and checking them upon receipt from the pharmacy and the person was responsible for administering their medicines. The risk assessment also stated that the person had a safe in their bedroom which was for the storage of medicines. However, when we checked this the person's medicines were not being kept secure in the safe as detailed on the risk assessment. Senior staff and the registered manager were aware that these were being kept in an unlocked drawer in the person's bedroom, which could have been accessed by other people. We raised this concern with the registered manager, who took action to ensure that the medicines were stored safely.

All other medicines were stored securely and systems were in place to ensure they were kept at the correct temperature. There were clear processes in place to obtain, store, administer, record and dispose of medicines. Medicines were only administered by staff who had completed relevant training and been assessed as competent to administer medicines.

We found that most areas of the service were clean, however we identified some areas which could not be adequately cleaned, due to wear and tear. For example, within the laundry, the floor was damaged and no longer water-resistant, therefore effective cleaning could not take place. We also identified there were no hand washing facilities within the laundry room, which posed a risk of contamination. In one bathroom, we saw chipped paintwork around the base of the toilet pedestal with the wood underneath exposed; and a peeling bath surround had not been repaired. This would also prevent adequate cleaning, and pose a risk of contamination in these areas.

The provider had assessed specific infection control risks, and procedures were in place to manage these risks. However, specific measures to reduce the risk of Legionella by performing weekly flushes of little used water outlets had not always been completed. The registered manager identified that there was no process in place to do these checks when the maintenance person was on leave, and stated they would ensure a second staff member was nominated to do these. We also noted that the providers risk assessment had identified specific training was required for the maintenance person in respect of Legionella, however this had not occurred.

The failure to detect and control the risk of infection is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the standard of cleanliness in the service. One person told us, "The cleaner does my cleaning and washing, I don't have to do anything like that." Another person said, "They [staff] sort it, I think they do a good job". Staff had attended infection control training and had access to personal protective equipment (PPE) and wore this whenever appropriate.

People felt safe at Appley Cliff. One person said, "The staff are nice, I think it's safe here." Another person told us, "Yes I feel safe, it's safe here." Staff had received safeguarding training and knew how to identify, prevent and report abuse. They were confident that the registered manager and providers senior managers would respond to any concerns they raised. Records confirmed that the registered manager had reported incidents appropriately and promptly to the local safeguarding authority, and had taken any necessary action to ensure people were safe.

We looked at records of detailed risk assessments for people, which were kept in their care plans. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, one person had a risk assessment in place which stated they had chosen to mobilise with their legs in a position that is not recommended for their wellbeing and safety. Where people had capacity to choose not to follow their care and support plan, they had signed a 'managing decisions and risks form', which detailed the risks and benefits of not following the recommended plan, and strategies that had been put in place to help staff and the person manage the risk.

Although most individual risks were managed effectively, we found staff were not always sure of how to check equipment used to mitigate risks to people. For example, we discussed the use of pressure relieving mattresses with staff, who were unsure of the settings on the mattresses and confirmed they did not know how to check they were set correctly or how to change them. One staff member said, "They are not our responsibility. The district nurse looks after them". However, staff spoken with agreed they should know the correct procedures for managing people's mattresses safely, and said they would speak with the district nurses.

At the start of the inspection, we noted a sign in the accessible kitchen area to remind staff and people of actions to be taken to avoid potential harm when using the kettle, and how this must be managed. The notice specified that the kettle should be emptied of hot water and the lead placed in a cupboard. However this had not occurred on the day of the inspection, the kettle felt warm to touch on the outside, was half full and the lead remained attached. This could place person at risk of experiencing scolds. We identified this to the registered manager who took action to empty it and place the lead in the cupboard. They also spoke with staff to remind them of the correct procedure to manage the risk.

Other environmental risks had been assessed robustly and were monitored to make sure people were protected from avoidable harm. We saw records to show that checks on the building and equipment in use were being carried out, and gas and electrical appliances were serviced routinely. Where required, remedial action had been taken and environmental risk assessments were updated.

The service had an accident and incident reporting system in place. We reviewed records which showed that where accidents or incidents had occurred, there was a process in place to document these appropriately and reviews had been undertaken to identifying any patterns or trends, and actions that could be taken to prevent similar incidents in the future.

There were plans in place to deal with foreseeable emergencies. Fire safety equipment was maintained and checked regularly, and people had Personal Emergency Evacuation Plans in place, (PEEPS). These included details of the support people would need if they had to be evacuated. Staff were aware of the action to take in the event of a fire, and told us about fire safety training they had received. They also confirmed they had all necessary equipment to manage an emergency and we saw fire extinguishers and evacuation equipment were located around the service.

There were sufficient staff to meet people's care needs. One person said, "There are enough staff." Another person told us, "The staff are here when we need them." During the inspection we saw that staff were always available to support people, they did not rush and call bells were responded to promptly. Staff told us there was usually enough staff to meet people's needs. One staff member said, "There are enough staff most of the time, if someone is off sick, they try to get it covered." Another staff member told us, "We have time to do everything, the manager will help if needed."

Staffing levels took into account the number of people who were living at the service and the level of support they needed. The registered managed told us that duty rosters were completed manually to ensure a suitable skill mix of staff for each shift, and a 'shift leader' was always available. Absence and sickness were covered by existing staff working additional hours or bank staff where required. The service also had number staff who were employed in a non-caring role, but were appropriately trained to be able to care and support people. This meant that when there was an emergency or staff absence, other staff members were available to step in and cover care shifts at short notice.

There were safe recruitment procedures in place, which included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed appropriately before new staff started working with people. People were included in the recruitment of new staff. One person told us they had helped to interview new staff, and felt their views about the applicants had been listened to. There was a formal approach to interviews with records kept to demonstrate why applicants had been employed.

Good

Is the service effective?

Our findings

People were provided with the care and support they required. People's needs and choices were fully assessed and recorded in their care plans, which were regularly reviewed and updated. Updates on people's needs were also shared in a written handover log kept in the staff duty room, and staff told us they always received adequate information at the start of each shift. People's care plans were written in a format under headings such as 'Things I want to achieve', and, 'Things you need to know or do to support me', and people told us they had freedom to live their lives how they chose to. For example, one person said, "Yes, I can have a shower whenever I want."

People told us they were supported to access health care services and medical professionals such as dentists, opticians and doctors. They also confirmed that staff would organise transport for appointments, and accompany them if required. One person said, "They [staff] will ask the doctor or nurse to see me if I'm ill." Staff knew what action to take if people required first aid and confirmed they had received first aid training, which we viewed records of in staff recruitment files. They also spoke with us about people's specific health needs and when an ambulance should be called, or additional medical support would be required.

Records confirmed that people received regular visits from health professionals such as district nurses, to manage their health conditions. Where staff were responsible for administering specific medicines, they told us if they had any concerns they would ask the district nurse for advice or contact a doctor.

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. All people living at Appley Cliff were able to make day to day decisions for themselves, such as what they did and how they spent their time each day.

Staff had an understanding of consent, and were clear about people's right to refuse care and support. We spoke with staff about the actions they would take if someone refused personal care, they told us, "We would return later, or try a different staff member." We also looked at the medical administration records for a person who had refused to take a prescribed medicine on one occasion, which demonstrated people were able to freely refuse medicine and staff respected this. People's care plans contained various consent forms, such as consent to having care and support and consent to having photographs and videos taken. The forms explained in detail what they would be used for and had been signed by the person.

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 services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being

met. Everyone living at Appley Cliff was free to come and go on their own if they wished to, therefore there had been no necessity to apply for DoLS.

Adaptations had been made to the service to make it as supportive as possible for the people who lived there, within the structural limitations of the building. For example, people had level access to the garden and we saw people using the garden throughout the inspection. Two people living at Appley Cliff smoked cigarettes, which had previously caused complaints from other people due to the use of a rear placed conservatory as a smoking area. Since the concerns were raised, a smoking shed had been built outside of the service and fire blankets were provided to ensure people's safety when smoking.

With the exception of the laundry floor, the service environment was clean, tidy, and designed to meet people's needs. For example, the corridors were large and accessible to people who used wheelchairs or motorised chairs. In addition, people's bedrooms had been decorated in a style that they had chosen and there were personal objects and photos in each person's room, to reflect their interests and hobbies. However, we identified a number of areas that needed redecoration and refurbishment. We discussed this with the registered manager, who agreed that the main communal lounge was in need of a 'facelift', which would be taking place later in the year.

Where possible, people were encouraged to be involved with decoration decisions and environmental changes around the service. For example, the service had recently purchased new stools for the dining room, and people had been shown pictures of different styles and colours of stools to take a vote, before a decision was made on which ones would be bought. The registered manager also spoke with us about a successful art project that had taken place in conjunction with a local arts charity. The result was a large piece of colourful artwork displayed in the main dining room area of the service, which was created from individual pieces of art that everyone had designed. The registered manager told us that everyone had been involved in the project, even if they had been reluctant at first, and there were plans to create a similar piece of artwork in another communal area of the service.

People were complimentary about the food provided. One person told us, "The food tastes good, there is lots of choice." Another said, "Yes there is a choice, the food is good and they will get you anything you want." People also confirmed they could get drinks and food any time in the evening or overnight. Choices were offered for all meals, and people were offered alternatives if they did not want anything on the menu. For example, one person was eating sausage, bacon and eggs, which we saw was not listed on the menu for that day. Where meals needed to be soft or pureed, this was done separately for each different item of food on the plate, and consideration had been given to make the presentation look appetising.

Staff were attentive to people needs at meal times and provided support when required. For example, we saw a staff member cutting up a person's food at the table, following consent from the person. We also observed a staff member telling a person who had a visual impairment what was on their plate at different positions representing a clock face, i.e., 'potato at 2 o'clock, pork at 6 o'clock'. This helped the person to visualise what was on the plate and maintain independence with eating. Special aids were provided for people where necessary, such as high sided plates and assistive cutlery. Where people required full support to eat, this was provided by the same staff member throughout the whole meal, people were not rushed and they were involved in conversation to make the mealtime experience a sociable occasion. Staff considered people's safety at mealtimes, and made sure people were sitting safely and comfortably in a correct posture. If people required assistance with eating, staff asked them which side of the person they wanted them to sit.

New staff completed an effective induction into their role. This included time spent working alongside experienced staff until they felt confident they could meet people's needs. The registered manager had a

system to record the training that staff had completed and to identify when training needed to be updated. This included essential training, such as moving and handling, safeguarding adults and fire safety. Staff spoke positively about the training they received, one staff member said, "Yes, there is lots of training and they will organise extra if we think we need it." Another staff member said, "The training is good and there is lots of it."

Staff received regular one-to-one sessions of supervision with the registered manager or a senior staff member, to discuss their progress and any concerns they had. Staff who had been employed with the service from longer than 12 months also received an annual appraisal where they discussed their performance and development needs. We saw records of staff supervisions and appraisals in their staff files, which evidenced where staff needed to develop their skills, an action plan was in place. Staff spoke positively about the support they received from management on a day to day basis. One staff member said the registered manager was "easy to talk to" and they felt they "trusted her" to sort things out. Another staff member said they felt "listened to" by the registered manager and senior provider managers when they visited the service.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy living at Appley Cliff, and they were treated well by patient, kind and caring staff. One person said, "The staff are all nice people, friendly." Another person when asked if the staff treated them nicely said, "Oh yes." However, during the inspection we observed some interactions where people were not always treated in a kind and caring manner. For example, whilst we were sat in a communal area of the service, two people were sat by themselves without any interaction or stimulation for a period in excess of two hours. We observed a number of staff regularly walking in and out of the room, past the people, without making any interaction or communication. We also observed one staff member approaching someone in a mobile chair from behind and immediately move them into another room, without first explaining what they were doing or where they were going. The person appeared disorientated as they had not been informed of what was happened.

Additionally, we found that staff had not always considered people's dignity or valued people as individuals. For example, we identified in several people's bedrooms boxes of continence pads were stored on the floor and on top of people's wardrobes in clear view of visitors and people passing by the room. This identified the person as someone who had continence problems. Some parts of the service, including people's bedrooms were in need of redecoration and a number of pieces of furniture were worn and needed replacing.

At other times we did observe some positive interactions between people and staff. We noted staff engaged with people, made eye contact with them, knelt to their level when talking to them, and used touch appropriately to reassure people. Staff had also developed positive relationships with people and created a relaxing and calming atmosphere.

Staff told us about how they ensured people's privacy and dignity was respected when they completed their personal care. For example, covering people up as far as possible, ensuring the curtains are closed and the door is shut. People confirmed their privacy was respected when they were in the bathroom and their own bedrooms.

People were encouraged to be independent and do as much as possible for themselves. For example, some people had identified within their care plans that they wished to make their own drinks independently, and had been supported to do this using the facilities in the communal kitchenette area. The service also used electronic assistive technology to promote independence and maximise people's dignity. For example, we saw in some people's bedrooms there were devices to enable people to control various electrical items such as the television, lights and access to call bells when they were in bed. People's care plans contained information about what people could do for themselves, and what they needed assistance with. For example, one person's care plan stated, "I will undress myself and assist myself to bed." Another person's care plan said, "I am able to wash, dress and undress myself, although I would like help when I have a shower or bath." Where people required assistance with daily tasks, this was recorded and stated how this should be provided.

Staff had developed close relationships with people and knew who the people were that mattered most to them. We observed a staff member looking at photos with a person, it was evident that the staff member knew about the person's social background and life history, and knew the names of the person's family.

People were supported to express themselves in a manner that was appropriate to them. For example, one person had decorated their bedroom to reflect their favourite football team. Staff knew what team they supported, and told us they reminded the person of when the team was playing, and always ensured the radio was turned on so they could listen to matches. We spoke with the person, who told us despite the lateness of some football matches due to time differences, they were supported to watch them as staff knew how much they enjoyed this.

We discussed the use of advocacy services with the registered manager. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. The registered manager was aware of how to contact advocates if needed, and told us about when one person living at Appley Cliff had needed to use an advocate when they required a surgical procedure.

Confidential information, such as care records were kept securely and could only be accessed by those authorised to view them.

Good

Is the service responsive?

Our findings

People told us they were happy with the care and support they received at Appley Cliff, and could not identify anything they would change about the service or way they were supported. We spoke with an external health professional who was complimentary about the care provided for the person they supported. They said, "[person's name] is very happy, they don't want to move. I'm quite happy, [the service] is meeting my client's needs, I've got no concerns."

Initial assessments of people's needs had been completed when they moved into the service and care plans were developed to help ensure that peoples needs could be met appropriately. As part of the assessment process, relatives were involved to ensure staff had an insight into people's personal history, their individual preferences and interests. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels.

Each person had a care plan which contained individual information about their needs and how they wished them to be met. However, the information and records in some care plans did not always reflect people's specific needs, or support staff to ensure that people's needs were managed appropriately. For example, one person's care plan stated, 'Due to a medical condition, I must drink plenty of fluids. Staff to actively encourage me'. However, there was no hydration plan in place to support staff in understanding how much fluid the person should have or the action they should take if the person became de-hydrated, and there was no fluid monitoring being completed. We raised this concern with the registered manager, who confirmed there was no fluid plan in place, and agreed to review the need for a plan. Another person's care plan stated they were epileptic. Their care plan contained general guidance regarding seizure management and described the 'prolonged recovery time' in which an ambulance should be called, however this was not specific to the person and what the 'prolonged recovery time' would look like for them. We raised this with the registered manager who agreed the information in the person's care plan was not clear, and stated they would take action to resolve the lack of clarity.

The risks posed by non-specific information in the care plans were mitigated by the relatively low turnover of staff and the fact that staff knew people well. When we spoke with staff they all demonstrated an extensive knowledge of people, including their current needs, wishes and preferences. We also identified evidence in other sections of people's care plans of person-centred information about their needs, routines and how they should be supported. For example, one person's care plan said, "I like to a have a regular lie in the morning, and I like to stay up at night." Another said, "I like staff to put my medication into a pot all together and then I will take them with a drink."

People confirmed with us they were involved in care plans and knew what was in them. Where people had been assessed as having capacity, they had signed their care plans and we saw that regular reviews had taken place.

Although the service is for people with physical disabilities and who are not elderly, we found that people's care plans contained some information about their end of life care wishes, such as any religious and cultural

considerations, who they wanted to be involved and details about their funeral service arrangements. This meant that the registered manager and staff team had an awareness of what people would want at the end of their life. We discussed this with the registered manager who recognised their responsibilities around end of life care and the important discussions that needed to be raised with people and their families, so they could record wishes in people's care plans.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at Appley Cliff and thought it was well led. Staff spoke positively about working at the service and said they would recommend it to others as a place to work. Staff also said they would recommend the service to a relative if they needed the type of care Appley Cliff provides.

Quality assurance processes were in place, however we identified these were not always robust. The registered manager had processes to identify environmental risks and risks to people, such as a monthly health and safety check. However, these had not identified the issues we found relating to infection control, which had led to a breach of the regulation. Checks had also not identified the failure to ensure the service was well maintained or a concern over the safety of storing medicines in a person's bedroom.

The registered manager had a clear vision of how the service should run and worked with staff to develop a culture of supporting people to do things for themselves as much as possible. They described the values of the service as "empowering people to live the most independent life as possible", and, "encouraging people to achieve their goals and have a happy and fulfilled life." Staff shared the views of the registered manager and told us they felt the goals of the service were for people to be as "independent as possible, involved in the community, empowered to have a life, and help them with what they can't do."

People spoke positively about the management of the service. A health professional said, "I find [registered manager] very helpful, and generally I'm kept in the loop." Staff told us they felt supported by the registered manager and other senior management, and could raise concerns. One staff member said, "It's a different ball game here, I feel listened too. [Deputy manager] is very good at supporting me." Visitors were welcomed, the provider notified CQC of all significant events and the service's previous inspection rating was displayed prominently in the entrance hall.

The provider sought feedback from staff through annual staff surveys and staff meetings were held once a quarter. The registered manager told us that staff were given the opportunity to raise items they wanted to discuss on the agenda at the next staff meeting, through writing them on a noticeboard in the staff room. There was an open and transparent culture within the service and the registered manager told us they worked hard to encourage good values within the service. For example, they told us the topic of discrimination was often discussed during staff meetings, and how to value people with respect. We saw minutes from a recent staff meeting, which confirmed these conversations had taken place.

Monthly meetings were organised by the activities co-ordinator for people living at Appley Cliff, and minutes of the meetings were produced for people who were not able to attend. The registered manager told us that for people who were not able to read, staff sat with them to go through what issues had been discussed.

The service had a duty room for all staff, where a number of key policies were stored for staff to freely access, such as equality and diversity, safeguarding adults and whistleblowing. The registered manager also told us that the full range of policies was available on the provider's intranet pages, for staff to access if required.

Out of hours spot checks were completed regularly by the registered manager, deputy manager and regional manager and where issues were identified, an action plan was developed. The registered manager also completed weekly checks on the daily recordings of people's care and support documentation. We looked at records of where these checks had taken place, and saw that where an error in recording had happened on a particular day, this had been highlighted and handed over to the staff team on shift.

The service was a part of the provider's wider system of shared learning, where they could keep up to date with safety alerts and announcements. The registered manager also told us about the help and support they received from the provider's corporate teams, such as a weekly news brief from the 'Quality Team'. They said, "I can always pick up the phone to them for help."

The registered manager told us that they had recently attended training that had been delivered by the provider, which was focused on aiming for excellence and manager. They said, "I found it really interesting, we did some great work on change management." They also told us about meetings they had recently attended for a new electronic medicines management system that will be introduced within the service. They told us, "I came back and everyone was interested. I created that awareness and desire for change."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risk of, and preventing, detecting and controlling the spread of infection. Regulation (12) (2) (i).