Isle of Wight Council

The Adelaide

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Adelaide is a local authority run care home for short term respite and reablement support. Reablement is a way of helping a person to remain independent by giving them the opportunity to re-learn or regain some skills for daily living that may have been lost as a result of illness, accident or disability. The home provides accommodation for up to 24 older people, including people living with dementia. At the time of our inspection there were 11 people living at the home.

The Adelaide also provided a reablement service for a limited period in a person's own home that included personal care; help with activities of daily living, and practical tasks around the home. At the time of our inspection they were supporting 19 people in their own homes, four of which were considered to have 'long-term needs' and were waiting to be passed on to a private care agency

There was no registered manager in place for the service. The previous registered manager had retired three weeks before our inspection. A new manager was in post but had not yet registered with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People told us they felt the home was safe. Staff and the manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people across the whole service were personalised and provided sufficient information to allow staff to protect people in the least restrictive way whilst promoting their independence.

There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner. People were supported by staff who had received an induction into the service and appropriate training, professional development and supervision to enable them to meet people's individual needs.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff sought people's consent before providing care and understood the need to follow legislation designed to protect people's rights.

Staff developed caring and positive relationships with people, were sensitive to their individual choices and

treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. In the residential part of the service mealtimes were a social event and staff supported people, when necessary, in a patient and friendly manner.

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when engaging with people who had difficulty in communicating verbally.

People and, when appropriate their families, were involved in discussions about their care planning, which reflected their assessed needs.

There was an opportunity for people and their families to become involved in developing the service and they were encouraged to provide feedback about the service provided. This was both on an informal basis speaking to people and through a survey completed by people using the residential part of the service at the end of each period of respite. People supported in their own homes completed the survey when they were discharged from the service.

People told us they felt the home was well-led and were positive about the manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the service. They were also supported to raise complaints should they wish to.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

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.

People and their families felt the service was safe and staff were aware of their responsibilities to safeguard people from abuse. People received their medicines at the right time and in the right way to meet their needs.

The senior staff had assessed the health risks to people using the service. Where people were supported in their own homes individual environmental risks were identified and managed appropriately.

There were enough staff to meet people's needs and a duty roster system provided the opportunity for short term absences to be managed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service. Staff were supported appropriately in their role and could gain recognised qualifications.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

People were involved in developing their care plans and identifying their needs.

The manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The manager adopted an open and inclusive style of leadership.

People and their families had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

The Adelaide

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

The inspection was unannounced and was carried out on 22 and 27 September 2016 by one inspector.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

The service provides a mixture of residential care and care in people's homes. We spoke with a total of seven people using the service and the friend of another person. We also spoke with a health professional and received feedback from two others. We observed care and support being delivered in communal areas of the home. We spoke with five members of the care staff, a reablement leader, a reablement coordinator, three assistant managers, the chef and the manager.

We looked at care plans and associated records for eight people using the service, staff duty records, four staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

The service provides a mixture of residential care and care in people's homes. People across the whole of the service told us they felt safe. One person said, "Oh yes, I definitely feel safe. The girls are so supportive and make me feel much more confident". Another person told us they felt, "100% safe. They [staff] are always there is you need them. Just push your buzzer and they are there". Other comments included "Yes safe, there is always someone nearby" and "Very safe". A person visiting their friend in the residential part of the service told us, "Now [my friend] is here, he is safe. They really look after him well". The health professionals we spoke with told us they did not have any concerns regarding people's safety. One said, "Yes, safe. [People] are well looked after. I have not seen anything that concerns me".

People across the whole of the service experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the manager had received appropriate training in safeguarding. Staff were clear about their safeguarding responsibilities and knew how to raise concerns and to apply the provider's policy. One member of staff told us, "I have done my safeguarding training. If I saw anything I would go to my line manager. If they couldn't sort it out I would go to [the manager]". They were also aware of external organisations they could raise concerns with, such as CQC or the local authority safeguarding team.

Although no safeguarding concerns had been raised at the home since our last inspection, the manager was able to explain the action they would take when a safeguarding concern was raised with them, including reporting it to the appropriate authority in a timely manner.

People across the whole of the service were protected from individual risks in a way that supported them and respected their independence. The manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. One person, who was at risk of falling, had a risk assessment in place in respect of the support staff should offer to help them mobilise. Staff who supported people in their own homes told us comprehensive risk assessments were completed to manage risks posed by the environment. For example one person receiving support in their own home had a risk assessment alerting staff to the danger of loose rugs within the home. Where an incident or accident had occurred, there was a clear record, which enabled the manager to identify any actions necessary to help reduce the risk of further incidents.

People across the whole of the service told us there were sufficient staff to meet people's needs. Their comments included, "There are always staff walking around and checking if you need anything" and "definitely [enough staff] if I ring my bell they are there in a jiffy asking what you want". People who were supported in their own homes told us staff were not rushed and had time to chat while they supported them.

The manager told us that staffing levels in the residential side of the service were based on the anticipated needs of the people using the service. They explained that although the occupancy level at the home

fluctuated daily dependent on people's respite requirements, staffing levels in the residential side remained constant and there were sufficient to meet the needs of people when the home was full. Staff supporting people in their own homes were employed on a shift basis which meant senior staff were able to plan the allocation of people to specific teams ensuring there were sufficient staff to meet their needs.

The staffing levels across the service provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed. For the residential part of the home this was managed through the use of overtime, staff employed by the provider at other homes and the provider's bank staff. The short term absence of staff providing support in people's homes was covered by other members of the team. The management team were also available to provide extra support when appropriate. When staff who provided support in people's homes had some spare time within their shift, they helped support people in the residential side, for example by helping to bath people, run entertainments etc.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

People across the whole of the service received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed by the manager to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving them to them.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly. An emergency bag and file had been prepared, containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support people would need if they had to be evacuated in an emergency. Staff had been trained to administer first aid.

Good

Is the service effective?

Our findings

The service provides a mixture of residential care and the provision of care in people's homes. People, across the whole of the service told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "I came here from the hospital. They [staff at the home] arranged it all. I needed a doctor to review my tablets so they called one out for me". Another person told us that staff, "understand my needs. They know what to do and how to do it". A visitor said, "The care here is second to none. The staff know what they are doing". A person being supported in the community told us staff were, "aware of my needs. There is a folder here to explain [what I need doing]. We work it out together". Health professionals told us they felt staff had the skill to meet the needs of the people they supported. One health professional said, "I have observed staff doing transfers [supporting people to mobilise]. Their moving and handling is done how it should be done".

When appropriate people's ability to make decisions was assessed in line with 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. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. The manager told us that none of the people using the service lacked capacity to make their own decisions.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was aware of the necessary requirements. However, none of the people using the service required DoLS application to be made. Staff had been trained in MCA and DoLS and were aware of their responsibilities under the Act.

People across the whole service told us that staff asked for their consent when they were supporting them. One person said staff, "check first before they start helping me. If I say I don't want to have a wash yet they say I will come back later". Another person told us, "They [staff] always check I am happy before they do anything". Staff supporting people in their own homes told us that when they spoke with the person, they checked the person understood any decisions they were asked to make. One member of staff said, "Everyone is so different. We check with them before providing support". People receiving support within their own homes were able to make decisions independently or with a little support from their families.

We observed staff seeking consent from people using simple questions, giving them time to respond. Care plans included signatures from people indicating their agreement with the care and support that was planned. When their care was reviewed and changes were made, they were invited to re-sign the record to show that they had been involved and had agreed to the changes. Daily records of care showed that where

people declined care this was respected.

People across the service were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. A member of staff told us, "We get regular training. I have done dementia training, first aid and safeguarding. I am also doing my NVQ 2 [which is a vocational qualification in care]". Staff who were new to care received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness, Mental Capacity Act and deprivation of liberties safeguards, end of life care, falls prevention and catheter care. Staff were also supported to undertake a vocational qualification in care. One member of staff told us, "If we need training we ask for it and they arrange it. The last one I did was catheter training as we are getting people coming in with those now". A catheter is a device used to drain a person's bladder through a flexible tube linked to an external bag. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who had difficulty in mobilising to maintain a level of independence.

Staff across the whole service had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff said, "I have a supervision with my manager every couple of months. It is a two-way process and if you ask for any extra training they will sort it out".

People across the whole service were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said, "The food is brilliant. You get two choices at lunch and tea time. I can have as much drink as I want. I prefer water at lunchtime and then tea in the afternoon". Another person told us, "The dining room is nice; you can sit with who you want and make friends". A third person said, "The food is very good. I am a vegetarian and they cater for me. They give you a choice of what you want and you can say if you want a small or a big one [portion]". A visitor told us their friend who they were visiting "had been at the hospital all morning so he wasn't hungry [at lunchtime]. So they have put him one [a meal] off".

The chefs who prepared people's food in the residential part of the service were aware of people's likes and dislikes, allergies and preferences. The menu was published on a noticeboard daily to inform people of what options were available. These included a main meal, a light choice and a vegetarian option. People could also have an alternative, such as a jacket potato, salads or steamed fish if they didn't want what was on the menu. People were also offered a choice about the size of the meal they preferred, small, medium or large.

Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. People were able to choose where they sat and were not rushed to eat their meals and we observed lots of laughter and chatting between people sat at the tables. During the meal staff checked with people that their food was okay and checked whether they would like any extra helpings. One person had requested not to have peas. When their meal arrived it had peas on the plate. The member of staff immediately apologised and said "I will get you a

different one without peas". We saw they came back after a few minutes with a different plate with no peas as requested. Staff were aware of people's needs and offered support when appropriate. Drinks, snacks and fresh fruit were also offered to people throughout the day.

People who were being supported in their own homes were verbally encouraged to eat and drink enough. Procedures were in place to record people's intake if they were at risk of malnutrition and dehydration, but nobody was considered at risk currently. In most cases, people's meals were prepared by family members and staff had very little input. The goal for one person was to be able to make their own lunch and staff supported them to achieve this. We spoke with this person who said, "Staff are so encouraging; I am able to make my own breakfast now".

People across the whole of the service were supported to maintain good health and had access to appropriate healthcare services. Their records showed people were referred to specialists when needed. For example, one person was found to have a problem with their catheter and a doctor had been contacted for advice and guidance. Where health professionals were involved in people's care, all appointments and the outcomes were recorded in detail. One person told us, "While I am here they [staff] have arranged for the nurse to come in every day to do my injections". A health professional, said, "If we give advice or ask them [staff] to do something they take it on board and do it". They added "Staff all seem to know what they are doing. They make sure medication we need is here when we need it. They seem on top of things".

Good

Is the service caring?

Our findings

The service provides a mixture of residential care and the provision of care in people's homes. Staff across the whole service developed caring and positive relationships with people. One person said, "I am very happy here. The staff are lovely, caring, patient. They are all very kind. It is nice when I come here". Another person told us, "Staff are wonderful, they will go to any lengths; you only have to ask". They added staff "have a good sense of humour, they like a joke". We observed this person enjoying some friendly banter with different members of staff. A third person said, "Staff are wonderful. They are like my second family; they will do anything for you". Other comments from people included "Staff are very good, very helpful", "So cheerful", "Staff are delightful, very caring and they enjoy their work" and "They are lovely". A visitor said, "This is a fantastic place, I can't praise the staff enough". Health professionals told us staff were very caring and patient with the people they supported. One health professional said, "People are well cared for here".

People across the service were cared for with dignity and respect. Staff spoke with them with kindness and warmth and were observed laughing and joking with them. The manager approached one person who was sat at the table waiting for their lunch and crouched down so they were at the same level and quietly informed them the doctor had arrived. The person was concerned about her meal and the manager patiently reassured her they would ensure her meal was kept for her. She then offered to assist the person to stand by moving their chair for them. Staff were attentive to people and checked whether they required any support. One person told us, "They [staff] are always asking if you want a drink or if you want anything else".

Staff across the service understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Arrangements were in place to check whether people were happy to receive personal care from male or female care staff and their wishes were respected. People were offered choices in line with their care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected.

Personal care across the service was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described the practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. One person said, "Staff help me wash. They are very respectful and patient". Another person told us, "They [staff] are always respectful. They knock before they come in and are always polite". A third person said staff "always knock, never walk in without knocking. If the door is open they go 'knock knock'.

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of

people's needs and their likes and dislikes.

People across the whole service were encouraged to be as independent as possible. Care plans encouraged staff to promote people's independence. One person said, "Staff encourage you to do things like coming down stairs". Another person told us "Staff are always trying to get me to do things for myself". A third person said that staff "help me get up, wash and dress; I do as much as I can. It is part of the healing process". A member of staff told us, "I try to promote independence as much as I can. I ask them if they want my help and whether they can do it themselves. Lots of people are very private, which we respect". We observed another member of staff supporting a person to mobilise out of a chair. They encouraged the person to push down on the arms of the chair to stand by themselves, placing a hand gently on the person's back to provide reassurance and support.

People across the service were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. All of people and families we spoke with confirmed that the manager and staff supported people to maintain their relationships.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Good

Is the service responsive?

Our findings

The service provides a mixture of residential care and the provision of care in people's homes. People across the whole service told us they felt the staff were responsive to their needs. One person said, "I can't sing their [staff] praises enough. They are like one big family; they try and encourage you to do activities but I don't feel like it at the moment. They don't mind". Another person told us "It is nice here, informal, a home we can come for a break. Everyone [staff] is here to help you, you just have to ask". Other comments from people included "I am grateful for the help they give me", "They check every day what I want them to do" and "I come here regularly so they know me and know what I need. They are lovely". A visitor told us staff "stepped in when [my friend] came out of hospital. Their care is fantastic, just what he needed". Health professionals told us they did not have any concerns about how staff responded to people's needs.

Staff across the whole service were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond.

People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's, understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. They also included specific individual information to ensure medical needs were responded to in a timely way. One member of staff told us, "I look at the care plans all the time. They are very helpful because we have a turnover of residents and people's needs change".

Staff supporting people in their own homes understood people's needs, their goals and how these should be achieved. They were clear that the purpose of the service was to support people to regain their confidence and develop essential life skills. However, care plans for people in their own homes were generic and did not always support the delivery of care for that person's individual needs. For example one care plan informed staff to 'assist [the person] with some aspects of dressing'. This did not provide staff with the information necessary to understand which aspects of dressing they should assist with and which aspects they should support the person to do themselves to encourage independence. The manager agreed this was an area that could be improved and agreed to explore how the care plans for people in their own homes could be developed to include more individualised information.

In the residential part of the service, care plans and related risk assessments were reviewed at the start of each period of respite to ensure they reflected people's changing needs. The care delivered to people living in their own homes was reviewed on a regular basis. The assistant manager, the team leader and office staff monitored and assessed the progress each person was making towards their goals and to identify any changes that were needed. The person would have already contributed to this review through the team leader. One person told us that when they started, "[the reablement leader] came out and went through things and asked what I needed. She has been back to check if things are okay and if things have changed". Reviews usually resulted in the gradual withdrawal of support, which tapered off to coincide with the end of

the planned six week reablement package. Occasionally, the review identified that a person needed more support than they were receiving and this was arranged.

People across the whole of the service received care and treatment that was personalised and they or their relatives were involved in identifying their needs and how these would be met. People had signed their care plans to confirm they had been involved in the planning process. One person told us they regularly stayed at the Adelaide. They said, "When I come in they go through their forms to check if anything has changed and what I need". Another person said, "I came from hospital; when I arrived they [staff] went through everything with me again". A member of staff told us, "When they [people] come in we try and keep them to their normal regime. We do their care plan and then it is checked by [the manager or assistant manager] who reads them all through".

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person who required a hoist to mobilise needed. We spoke with the person and they told us, "I need a hoist because I can't stand by myself. There is always two staff when they do it. They check I am comfortable and if it is pinching. There are always talking to me [while using the hoist]. They know what to do and how to adjust the straps". Handover meetings were held at the start of every shift, in the residential part of the service. These provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

Staff in the residential part of the service were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. People had access to activities that were important to them. During the inspection we observed people being encouraged to take part in an arts and craft session. Those people who took part told us they enjoyed the opportunity to make things and engage in activities. Where people did not want to engage in group activities staff interacted with them on a one to one basis. One person told us, "There are always activities [going on] but you don't have to join in if you don't want to. I don't like to join in much. I like playing bingo, cards and scrabble". People supported in their own home were encouraged to engage in activities that helped to maintain their independence and life skills.

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. The manager sought feedback from people staying in the residential part of the service on an informal basis when they met with them at the home or during telephone contact. The manager also sought formal feedback through the use of quality assurance survey questionnaires. These were completed by people using the residential part of the service at the end of each period of respite and by people supported in their own homes when they were discharged from the service. All of the comments in the feedback forms we viewed were positive. These included, 'To all the wonderful staff X X X', 'I could not ask for better', 'Pleasant stay; wonderful staff' and 'A big thank you to the chef for providing a soft diet and making sure I had something different when unable to eat what was on the menu'.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. All of the people we spoke with knew how to complain but told us they had never needed to. The manager told us they had not received any complaints since the home was last inspected and was able to explain the action that would be taken to investigate a complaint if one was received. They explained that minor concerns in the residential part of the service

would be dealt with informally and if the person still wasn't satisfied they would record it as a formal complaint and follow the provider's complaints process. In addition, for people supported in their own homes there was a 'log of issues', which included accidents, incidents and minor complaints. These were reviewed by managers to identify any lessons that could be learnt.

Good

Is the service well-led?

Our findings

The service provides a mixture of residential care and the provision of care in people's homes. There was no registered manager in place for the service. The previous registered manager had retired three weeks before our inspection. A new manager was in post but had not yet registered with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People told us they felt the service was well-led and they would recommend the service to their families and friends. One person told us the residential part of the service was "definitely well led. That's the person in charge [indicating the manager who was walking through the lounge area]. She speaks to me every day and asks if everything is alright". Another person said, [The registered manager] has just retired and [the new manager] is just as good. We have affectionate greetings when I see her". A visitor told us, "I would definitely recommend the home. I have no worries at all; they really know how to look after [my friend]". People who were supported in the community told us that when they needed to contact the office they were "very Good" and "on the ball". Health professionals told us they did not have any concerns over the management of the home. A health professional said the service "appears well led. I am impressed with what I have seen. Never have any concerns. Never heard anything bad about the Adelaide".

There was a clear management structure, which consisted of a manager, assistant managers with specific responsibility for either the residential part of the service or supporting people in their own homes, senior staff and the group manager for short term services. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One member of staff told us, "I feel very involved in running the home. I also get involved in running the activities. If I want to bring anything up then it is no trouble". Another member of staff said, "I think the management team are effective here". Staff supporting people in the community told us they had a "good management team" and there was an out of hours team so they could always contact someone if they needed to.

The provider was fully engaged in running the service, through the involvement of the group manager who reinforced their vision and values. These were built around supporting people as individuals to enable then to regain their confidence, life skills, help reduce the risk of isolation and provide support to their families. Care staff were aware of the provider's vision and values and how they related to their work. People told us they were given the opportunity to provide feedback about the culture and development of the service. People all said they were happy with the service provided.

The frequency of staff meetings varied between the residential part and the team supporting people in their own homes. However, staff told us there were sufficient meetings to provide the opportunity for the management team to engage with staff. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They

confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed.

The provider had suitable arrangements in place to support the home's management team, through the group manager for short term services. The manager told us they felt supported as a result of regular meetings with the group manager, which also formed part of their quality assurance process. They were also able to raise concerns and discuss issues with the registered managers of the other services operated by the provider if they needed to.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The manager carried out regular audits which included infection control, the cleanliness of the home, medicines management and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, health and safety and fire safety. Some of these checks were carried out by external professionals. The manager also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

The care records for people supported in their own home were checked by team leaders and managers when they visited the person, to help ensure staff were delivering care and support in an appropriate way. In addition, when care packages had been completed, the notes and records were returned to the office, where they were audited by one of the assistant managers.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority safeguarding team or the Care Quality Commission if they felt it was necessary.

The provider and the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The manager was responsive to the concerns and suggestions raised by the inspection team during the inspection. The rating from the previous inspection report was displayed in the reception area and on the provider's website.