Aitch Care Homes (London) Limited

Sheringham House

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

Overall summary

The inspection was carried out over the course of two days on 07 November 2014 by two inspectors. It was an announced inspection. The service provides care and accommodation to ten adults with learning disabilities. There were ten people living in the service at the time of our inspection. All the people who lived in the service had varied communication needs. Some people were able to express themselves verbally; others used body language to communicate their needs. Some of the people's behaviour presented challenges and was responded to with one to one support from staff while some people were more independent.

We told the provider two days before our visit that we would be coming to allow time for the staff to prepare people who may experience anxiety about unfamiliar visitors.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Staff were trained in the safeguarding of adults. They knew how to recognise signs of abuse and how to raise an alert with the local authority if they had any concerns. Staff were also trained to de-escalate people's behaviours which challenge with distraction techniques that preserved people's dignity and did not use restraint. A member of staff told us, "We anticipate and think of how to defuse a situation while not taking control away from the person". Risk assessments were centred on the needs of the individual and included risks in the community. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow.

There were sufficient staff on duty to meet the needs of the people who lived at the home. We observed that staff had time to spend supporting people in a meaningful way that respected individual needs.

There were safe recruitment procedures in place. These included the checking of references and the carrying out of criminal records checks for prospective employees before they started work. A newly recruited member of staff told us, "I have just started my induction and have to learn as much as possible about each resident and read the policies of the service". All staff were subject to a probation period and to disciplinary procedures if they did not adhere to their code of conduct.

Medicines were stored and administered safely. Staff were trained in the administration of medicines and kept relevant records that were accurate and fit for purpose.

People lived in a clean and well maintained environment. Staff had a thorough understanding of infection control practice that followed the Department of Health guidelines and helped minimise risk from infection.

Staff had a good knowledge of each person and of how to meet their support needs. One person told us, "I have lived here for over two years and staff know me well." Specific communication methods were used to converse with people. We observed interaction between people and the staff and saw positive support that promoted people's independence and protected their rights.

Staff had appropriate training and experience to support people and their complex needs. They had received a thorough induction and had demonstrated their competence before they had been allowed to work on their own. All staff's annual training was current and staff had the opportunity to receive additional training specific to the needs of the people they supported. Two members of staff told us, "We get full support and can discuss any concerns" and, "We get encouraged to gain qualifications and study".

People's quality of life was enhanced by the layout of the premises and the facilities they offered. People's own rooms were personalised and adapted for individual needs. There was a large enclosed garden, currently laid to lawn that contained a separate summer house structure that had been fitted out with sensory equipment and heated.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). All care staff and management were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

We saw that food was prepared and people supported to eat at different times to accommodate their different needs and the challenges that meals times posed for some people. Staff knew about people's dietary preferences and restrictions such as how one person could not tolerate certain foods and fluids.

The service was caring because staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect. People who were able to talk with us told us they were satisfied with the way staff cared for them. One person told us, "The staff are very good and kind". A relative of a person who lived in the home told us, "The staff are simply brilliant, they are like an extended family and the care is excellent".

The service provided clear information about how to communicate with people.

Healthy living and wellbeing was promoted by staff. Specialist equipment was provided. Frequent general wellbeing checks were recorded by staff at regular intervals. Health care professionals' visits and referrals were routinely facilitated. People were supported by staff when they were hospitalised. The manager told us, "We will always stay with them to make sure they are not anxious, advocate when necessary and facilitate two-way communication with the hospital staff".

Summary of findings

People's individual assessments and care plans were reviewed regularly with their participation or their representatives' involvement. These were updated to reflect people's changes of needs, wishes, preferences and goals. The delivery of care that we saw being provided was in line with people's requirements, as outlined in their care plans.

A wide range of activities was available. The registered manager told us, "We are always on the look-out for new activities that people would enjoy".

People's feedback was sought and they were involved in the planning of the delivery of their care. Complaints, comments and suggestions were taken into account and acted on. People participated in monthly residents meetings and yearly satisfaction questionnaires were sent to stakeholders and people's relatives or representatives to collect their feedback. All feedback was analysed and improvements were made. Transition between services was handled with sensitivity by staff who considered people's psychological wellbeing.

The service was well led because there was an open and positive culture at the service which focussed on people. Staff told us, "The manager and deputy managers are very approachable, we can talk to them any time and discuss any concerns". The manager had been in post under one year and had implemented changes in the service. New activities and new documentation that supported staff's practice had been introduced. The manager told us, "We have to be pro-active and interactive, and the more ideas we can explore the better".

The staff confirmed the registered manager was supportive and understanding of the challenges they encountered. The manager was included in the staff rota and spent time caring for people. The manager told us, "I like to be 'on the floor' and work alongside the care staff; I do not want to be one of these managers who sit in their office and lose touch with the residents and what is happening". A member of staff told us, "He is a leader but he is also one of us".

There was a system of quality assurance in place to monitor the overall quality of the service and identify the needs for improvement. Satisfaction surveys were carried out. A regional operations manager inspected the service every month to check compliance with regulations and make recommendations. Recommendations were followed up and actioned within a set time frame. The manager carried out weekly and yearly audits to identify how the service could improve.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. Their training in the safeguarding of adults was current and appropriate.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs.

Safe recruitment procedures were followed in practice. Medicines were administered safely. People lived in a clean and well maintained environment.

Good

Is the service effective?
The service was effective.

Staff were trained and had a good knowledge of each person and of how to meet their support needs.

The registered manager had ensured that relevant applications to the Deprivation of Liberty Safeguards office were in process for people who were unable to leave the premises unaccompanied for their safety.

People were supported to be able to eat and drink sufficient amounts to meet their needs and people were provided with a choice of suitable and nutritious food and drink. People were referred to healthcare professionals promptly when needed.

Good

Is the service caring?
The service was caring.

Staff communicated effectively with people, understood their mood, responded to their needs promptly, and treated them with kindness and respect.

The staff promoted people's independence, healthy living and good health.

People were able to spend private time in quiet areas when they chose to. They were allocated one specific care worker with whom they spent time and developed a trusting relationship.

Good

Is the service responsive?
The service was responsive.

People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in line with people's care plans.

A wide range of activities based on people's needs was available.

The service took account of people's complaints, comments and suggestions.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

There as an open and positive culture which focussed on people. The manager operated an 'open door 'policy, welcomed people and staff's suggestions for improvement and maintained a pro-active approach.

There was a robust system of quality assurance in place. The registered manager carried out audits and analysed them to identify where improvements could be made.

Sheringham House

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.

The inspection was carried out by two inspectors over the course of two days on 07 November 2014 and 09 November 2014. It was an announced inspection. We told the provider two days before our visit that we would be coming to prepare people who may experience anxiety about unfamiliar visitors.

There were ten people living in the service at the time of our inspection. All the people who lived in the service had varied communication needs. Some people were able to express themselves verbally; others used body language to communicate their needs. Some of the people's behaviour presented challenges and was responded to with one to one support from staff while some people were more independent.

Before the inspection we looked at information the manager had sent to us about the service in their Provider Information return (PIR) which we asked them to complete. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We looked at records that were sent to us by the registered manager or social services to inform us of any significant changes and events. We reviewed our previous inspection reports. We consulted two local authority case managers who oversaw people's care in the service, an occupational therapist and a chiropodist who visited people regularly to provide treatment. We obtained their feedback about their experience of the service.

During our visit we looked at records in the home. These included six people's personal records and care plans, risk assessments, six staff files, staff rotas and training records, audits, and the service's policies and procedures. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered accordingly. We also spoke with three relatives of people who lived in the service.

We spoke with the manager, deputy manager, and six members of staff. We spoke with two people. Not all the people that lived at Sheringham House were able to communicate verbally with us. We used the Short Observational Framework for Inspection (SOFI), to capture the experiences of people who may not be able to express this for themselves. SOFI is a way of observing care to help us understand their experience. Using the SOFI tool helps to raise questions about care practice that is then followed up by checking other sources of evidence.

At our last inspection on 17 December 2013 no concerns were found.

Good

Is the service safe?

Our findings

We observed people's interactions with members of staff. People appeared relaxed and confident in the company of staff. We saw a member of staff gently reassuring a person with anxiety. A person was curled up on a sofa smiling while a member of staff sang to them. One person we spoke with told us, "It's okay living here. It's quiet and there are enough staff to help me. I have my key worker and that works out okay. If I have a problem I can talk to [the manager]. This showed that people felt confident that staff will ensure their safety. A relative of a person who lived in the service said, "I feel my loved one is in safe hands".

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. Their training in the safeguarding of adults was annual and current. A poster with pictorial information about who to talk to if people had any safeguarding concerns was displayed in the dining area for people and their visitors. This included contact numbers of the local safeguarding authorities.

The registered manager confirmed that no restraint were used and told us that staff were trained to de-escalate people's behaviour that challenged, with distraction techniques that preserved people's dignity. A member of staff told us, "We anticipate and think of how to defuse a situation while not taking control away from the person".

Risk assessments were centred on the needs of the individual. Accidents and incidents were recorded and monitored daily by senior staff and the registered manager to ensure hazards were identified and reduced. People's care plans included risk assessments relevant to the ingestion of inedible objects, choking, falls, and behaviour that may be challenging. Each risk assessment included clear control measures and guidance for staff to follow. We saw risk assessments for people in the service and in the community. In the service we saw what this meant in practice. For example, the kitchen door in the service that was previously locked was now left open at key times of the day to enable people to access it. The risk relating to boiling a kettle was reduced by the use of an insulated flask containing the person's favourite hot drink. When planning activities for accessing the community, staff visited proposed locations to assess risk to safety. One member of staff said, "We'll go there first, assess and try to minimise the risk but we can never fully eliminate it."

There were sufficient staff on duty to meet the needs of the people. On the day of our visit we saw that, as well as the registered manager and deputy manager, there were four members of care staff on duty to support eight people in the service. Three people were receiving one to one support. We saw staff had time to spend supporting people in a meaningful way that respected individual needs.

People came and went during the day, supported by staff to follow their planned activity schedule that included accessing local shops and recreational facilities. People were allocated one specific care worker with whom they spent time and developed a trusting relationship. These care workers co-ordinated all aspects of a person's care at the service and were called 'key workers'. Two people and their key workers return from a week long holiday during our inspection. We were told by one member of staff, "There's enough staff. Like anywhere, shortages can occur, through sickness for example but we can cover it most of the time through calling in a care worker who is known to the service and on stand-by." Another staff member said, "We have flexibility in the rota to build the shifts around the needs of the residents. So for example, if we know that a person will need two support staff when they are going on public transport we can factor that into the planning of the rota." The registered manager told us "We have a team of twenty three care workers including five senior care workers". The registered manager reviewed the care needs for people whenever their needs changed to determine the staffing levels needed and increased staffing levels accordingly.

The service followed safe recruitment procedures that included the checking of references and the carrying out of disclosure and barring checks for prospective employees before they started work. The manager told us that members of staff were subject to a 'performance improvement plan' when needed. These were individualised plans for staff whose practice needed to improve within a three months' time frame. The manager monitored staff's progress and checked that set goals had been achieved. All staff were subject to a probation period before they became permanent members of staff and to disciplinary procedures if they behaved outside their code of conduct.

All the people or their representatives when applicable chose to have their medicines managed for them. All people were aware that their medicines was being

Good

Is the service safe?

administered. There was an effective arrangement with the local pharmacy to deliver the medicines that people needed to stay well. Five senior care workers and two shift leaders were trained in the administration of medicines. We observed staff administer lunchtime medicines. Staff spoke knowledgeably about the medicines they administered to people using a system of pre-prepared individual medicines. One person received their medicines with their favourite food, in this case yoghurt. Another person received medicines in liquid form, as per the instructions in their medicine administration records. One person told us, “They give me my tablets and I don’t need to think about it”. We checked the records that helped to ensure the safe administration of medicines and found they were well maintained. All medicines were stored securely and were kept at the correct temperature to ensure that they remained fit for use. As the staff followed correct procedures, people were confident that their needs for medicines were met appropriately.

People lived in a clean and well maintained environment. All the bedrooms, bathrooms, communal areas and the kitchen were clean and odour-free. Staff had a thorough understanding of infection control practice that followed Department of Health guidelines and helped minimise risk from infection. When we asked staff about their practice in this aspect of care they were able to identify the member of staff who was the infection control lead in the service. They described the measures that were taken to ensure that the service was clean and free from the risk of infection. We saw a cleaning schedule was used to maintain the standards that were set. It allocated cleaning duties every day of the week. We saw staff use hand sanitizers and appropriate hand-washing facilities were available and were regularly used. Staff told us Protective Personal Equipment (PPE) such as gloves and aprons were readily available. We observed that staff wore PPE when appropriate and that they encouraged people to wash their hands after toileting and before meals.

People had individual emergency evacuation plans and the service had an appropriate business contingency plan in case of emergencies. Each person had a ‘missing person’ file ready to be given to emergency services if needed and a ‘communication passport’. Each bedroom had a call bell alarm system, which enabled people to call a member of staff when they needed assistance. Fire protection equipment was regularly serviced and maintained. All staff were trained in first aid and fire awareness. Senior managers were scheduled in an on call rota during out of office hours.

Good

Is the service effective?

Our findings

People's needs were assessed, recorded and communicated to staff effectively. The staff followed specific instructions to meet individual needs. One person told us, "I have lived here for over two years and staff know me well." One relative said, "I can sleep well at night because I know the staff are efficient and do what is needed when it is needed". The registered manager told us, "There is a full complement of staff with a stable core of eight staff who have been working here for four years or more".

Each person's needs had been assessed before they entered the service. This ensured that the staff were knowledgeable about their particular needs and wishes upon admission. People had their own key worker whose duty included advocating on people's behalf and communicating their wishes to other staff and management and update their personal files. Specific communication methods were used by staff to converse with people. This included pictorial aids, signing, effective eye contact and appropriate use of body language. We observed interaction between people and the staff, we saw positive support that promoted people's independence and protected their rights. We observed a handover from one shift to another and noted how any updates concerning people's welfare were appropriately communicated to ensure continuity of care.

Staff had appropriate training and experience to support people and their complex needs. Staff confirmed they had received a thorough induction and had demonstrated their competence before they had been allowed to work autonomously. Records showed training was up to date and staff had the opportunity to receive further training specific to the needs of the people they supported. This included training on behavioural support, epilepsy and mental health awareness. All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal. Two members of staff told us, "We get full support and can discuss any concerns at supervision and at any time" and, "We get encouraged to study and gain qualifications".

People's quality of life was enhanced by the design of the premises and the facilities they offered. The building was warm and welcoming. Communal areas included a separate lounge and dining room that were well used during our visit. People's art work was mounted on canvas prints on the walls and helped to create a personalised environment where expression of individuality was valued. People's own rooms were personalised and adapted for individual needs. For example, we saw a large pool table that took pride of place in one bedroom and reflected the person's individual's tastes and choices. Another bedroom was minimalist in décor and furnishings and reflected the personality, choices and support needs of that person.

During our visit, a person responsible for the maintenance of the premises was carrying our internal repairs and consulted the registered manager about the re-decoration that needed to be done. They followed a plan of improvement that was overseen by the registered manager. This ensured that people lived in a well maintained environment where hazards were reduced and a pleasant atmosphere was promoted.

There was a large enclosed garden, currently laid to lawn that contained a separate summer house structure that had been fitted out with sensory equipment and heating. This provided a quiet space accessible to all. Plans were under way to create raised beds to enable people to grow their own vegetables and flowers next summer. Plans were also in place to convert part of the dining room into an additional quiet area where people could relax when they wished not to use communal areas or their bedrooms.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the registered manager and they demonstrated a good understanding of the impact on people. They told us, "People have rights and all action taken must be in their best interest". The process of submitting applications for DoLS was applied and appropriately practised. For example, the registered manager had ensured that relevant applications for DoLS were in process for people who were unable to leave the premises unaccompanied for their safety. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation. One member of staff described to us the circumstances in which they may submit a DoLS application. This showed us staff knew what the legal requirements were in situations

Good

Is the service effective?

where it had been deemed necessary to restrict someone's freedom. We saw from the staff meeting minutes that the recent changes to the circumstances when DoLS applications should be made had been discussed.

The registered manager was in process of assessing people's mental capacity regarding specific decisions about their activities of daily living. The registered manager demonstrated a good understanding of mental capacity. They showed us new improved templates that were to be used for people's mental capacity assessments and these reflected the requirements of the MCA 2005. One person's legal representative told us, "Consent is always discussed each time I participate in care reviews"

Some people were supported by staff to eat and drink. We observed staff offered a choice of drinks throughout the day and healthy snacks. People were able to access the kitchen with assistance of staff and prepare drinks safely. We observed people were assisted at mealtimes to ensure they ate at a pace that minimised the risks of choking. One person who declined to eat a prepared dish was offered an alternative. The choice of menus was based on guidelines obtained from an internet website that promoted 'changes for life' and that provided pictorial healthy recipes. People's dietary requirements were discussed at team meetings. For example, we saw that meal portion sizes and the need to slow down the pace during meals to facilitate good digestion had been discussed.

Food and fluid intake was recorded daily for each person. People's weights were monitored and people were referred to health professionals if necessary such as when substantial changes of weight were noted. We saw an example of this and records indicated that prompt action had been taken. Food was prepared and people supported to eat at different times to accommodate their different needs and the challenges that meals times posed for some people. Staff knew about people's dietary preferences and restrictions. Specific dietary needs for people who had diabetes or for people who needed soft diet were respected.

Healthy living was promoted by the service and in practice. People had separate health files in which their medical, mental health needs and health care professional visits were recorded with clear objectives and recommendations for staff to follow. For example, a neurologist's recommendations were noted following a review of a person's care and recorded in their health file. People were weighed monthly and encouraged to eat healthy snacks and people's diet was monitored to ensure that satisfactory weight was maintained. Equipment such as seizure monitors was provided at night for people who were at risk of seizures to ensure prompt staff response. One wheelchair had been repaired to ensure continuity of a person's independence. People's state of health and general wellbeing checks were recorded by staff every morning, afternoon, evening and several times at night time. A reflexologist visited weekly and a chiropodist visited every six weeks.

People accessed an optician and dentist routinely every three to six months. People were referred to their GP, psychiatrist, neurologist, dietician, speech and language therapist and occupational therapists when needed.

Prompt referrals were made to relevant health services when people's needs changed. For example, a person whose weight had decreased had been referred to a GP and a dietician as soon as staff became aware of the weight loss. We saw one person wore corrective shoes to alleviate a curvature of their spine. Vaccination against influenza was carried out when people or their legal representatives had provided their consent. Routine blood tests were carried out for people who needed their levels to be monitored.

There were arrangements in place to manage the care of people who became unwell. When people were admitted to hospital, staff stayed with them and provided reassurance and practical help. The manager told us, "We will always stay with them to make sure they are not anxious, advocate when necessary and facilitate two-way communication with the hospital staff".

Good

Is the service caring?

Our findings

People told us they were satisfied with the way staff cared for them. One person told us, "The staff are very good and kind". Two relatives said, "The staff are simply brilliant, they are like an extended family and the care is excellent" and, "My family member is so happy there that he does not wish to come home sometimes".

During our inspection we spent time in the communal areas and we took time to observe how people and staff interacted. There was frequent friendly engagement between people and staff and staff responded positively and warmly to people. Some people who had difficulties with verbal communication sought reassurance and physical contact. Staff responded to these needs appropriately as per the communication guidelines in people's individual care plans and with confidence. For example, stroking their hand and maintaining effective eye contact. When time needed to be spent by staff to ensure people communicated their needs, they were patient and encouraging.

People were able to spend private time in quiet areas when they chose to. They were accompanied to a dedicated sensory room when they wished to relax or were able to remain in their room if they preferred. During our visit, a person chose to remain in their bedroom and staff checked on their wellbeing in a discreet manner. All staff gently knocked on people's bedroom doors, announced themselves and waited before entering.

Personal records included a dedicated folder about people's individual planning of care, goals and achievements. This contained records of people's life history, likes and dislikes and preferred activities. Each person's allocated key worker spent allocated time every week and every month to spend one to one specific time with them. During this time, they checked their toiletries and clothing to identify what needed to be replenished; they reviewed their health action plans and updated their folder with people's involvement. They liaised with families and advocated on their behalf. They arranged appointments, reviewed their support plans and risk assessments, and discussed with the person their wishes, goals and aspirations. For example, we saw a monthly goal had been updated to include a person's wish to eat independently.

The staff promoted independence and encouraged people to do as much as possible for themselves. For example, to carry, process and fold their laundry. One person was assisted to travel on public transport and go shopping. A care worker said "It is important to make sure people remain involved with their care and get a sense of responsibility". We observed two people return from holidays with their key workers and noted how they were encouraged to recall their experiences in a friendly manner. One person said, "I had a great time, I wanted to go swimming and I went and could not stop it was fun". The registered manager told us "The key workers build a relationship of trust with each resident and this means they build a rapport where people can be really understood". A senior care worker told us, "All the staff have a good relationship with the residents because we care for them as if they were our own family".

Clear information was provided to people and visitors. Each person had a pictorial activity planner they could refer to. Menus and pictorial information about how to raise a complaint were displayed in the dining area. One relative told us, "Everything is very clear and we are kept informed of any happenings" They confirmed that they were made to feel welcome at any time to visit without restrictions.

There was a booklet entitled 'Welcome to Sheringham House' that included an introduction to the service and facilities and that provided recommendations about how to respond to people's behaviour when inside the premises. The recommendations took account of the risks involved for the safety of people and for the visitors and were illustrated with examples. The booklet also contained an introductory paragraph on each person to explain how best to communicate with them and individual photographs. This made visitors aware of how best to communicate with people and respected people's dignity as this promoted understanding.

Good

Is the service responsive?

Our findings

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. One person's relative told us, "We are invited to take part for care reviews and we are considered".

People's personal records included a pre-admission assessment of needs, a personal profile, needs and risk assessments and an individualised care plan. Care plans were reviewed monthly by staff and twice yearly with people's relatives or representatives. These were updated to reflect people's changes of needs to ensure continuity of their care and support. For example, a care plan had been updated to reflect a change of medicines following a review of their medicines needs. Another care plan included instructions to staff about facilitating access to the kitchen following a re-assessment of behavioural support needs. This showed that people's care plans were updated in response to people's changing needs.

People's records of care and support were personalised to reflect people's wishes, preferences, goals and what was important to them. For example, they included 'My daily living skills', 'My activities and interest', 'How I travel', 'My mealtimes' and 'My feelings and behaviour'. A person who preferred a calm environment had access to quieter areas of the service throughout the day. Another who needed one to one supervision was accompanied by a care worker who respected their need for space and privacy. Two people attended church services every Sunday. This outing was facilitated by staff and the delivery of care that we saw being provided was in line with people's requirements, as outlined in their care plans.

We looked at ten risk assessments and found they were all linked to people's support plans and that measures to reduce the risk were implemented. For example a risk assessment about scalding led to staff taking safety measures with people's preparation of hot drinks; another risk assessment about the ingestion of inedible products led to staff taking precautions about the storing of toiletries; a risk assessment about seizures led to the provision of night-time specialised equipment. Behavioural support plans identified key triggers and how to reduce them, taking into account people's history, preferences and personalities.

A wide range of activities that were based on people's needs and wishes was available. A local authority case manager who had reviewed a person's care in the service told us, "The new registered manager seems full of good ideas about activities". The registered manager told us, "We are always on the lookout for activities that people would enjoy". For example, the manager had planned to purchase tickets for a person's favourite band concert, and had introduced hydrotherapy for a person who particularly enjoyed swimming. There were plans to reintroduce a person to horse-riding when it was discovered that they enjoyed this as a child. People attended a night club once a month. Staff had visited the night club and talked with the owner to ensure that people's musical preferences were respected and check that this provider took account of specific needs of people with learning disabilities. Other activities included cycling, bowling, outings to pubs and cinema, art and crafts, puzzles, listening to music. Some people took part in activities that involved 'fun with food' where they could enjoy different textures, smell and taste. The manager told us, "This sensory activity was recommended by a relative of a person and we have adopted it. It is a wonderful way to develop a tactile approach to communication. We responded to a specific individual need".

The service took account of people's complaints, comments and suggestions. People were aware of the complaint procedures. People's key workers checked with people that they were satisfied and helped them communicate if they were not. A relative told us, "There is a formal way to lodge a complaint but why should we use it when we know we can just talk with the staff or the manager and things get put right straight away". No complaint had been received over the last twelve months.

Transition between services was handled with sensitivity by staff who considered people's psychological wellbeing. For example, staff accompanied people during hospitalisation and outpatients appointments to alleviate possible anxiety and facilitate communication. The deputy manager told us, "Before a person enters the service, we visit them several times in their home to get to know their routine and they are encouraged to visit the service and stay for meals or overnight as often as they wish. This way they familiarise with their new surroundings more easily".

Good

Is the service well-led?

Our findings

Our observations and discussions with people, their relatives and staff showed us that there as an open and positive culture which focussed on people. People and members of staff were welcome to come in the office to speak with the manager and deputy manager at any time. Two people told us, "I just open the door and come in and talk and they are nice", and "I spoke to the manager just yesterday about my door not closing properly and it got fixed straight away." Staff told us, "The manager and deputy managers are very approachable, we can talk to them any time and discuss any concerns". The manager said, "We have an open door policy, we work as a team". We observed a person who entered the office several times during our inspection, they said, "I just want to be here for a while and watch you work". They were made to feel welcome by the registered manager and deputy manager who conversed with them.

The registered manager had nineteen years of previous experience in working in social care in the learning disabilities sector and in supported living management. The registered manager had been in post at Sheringham House under one year and had implemented changes in the service. This included new support plans, the use of a new key worker system and of personalised records which helped staff understand what was meaningful in people's lives. Records were well organised, comprehensive and easily accessible. New activities had been introduced, such as hydrotherapy and 'fun with food' tactile activities.

The manager told us how the service had developed a good relationship with their neighbours and how more involvement with the community was being researched. People were encouraged to take part in recycling schemes and this was presented as an enjoyable activity. Plans were underway to create gardening opportunities next summer. The manager told us, "We have to be pro-active and interactive, and the more ideas we can explore the better".

The manager consistently notified the Care Quality Commission of any significant events that affected people or the service and promoted a good relationship with stakeholders. This was confirmed by a local authority case manager who oversaw a person's care in the service. They told us, "This manager contacts and consults us when it is needed and keep us informed". Records indicated the registered manager took part in safeguarding meetings with the local authority to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

The manager researched websites that specialised in standards of residential care to obtain updates on legislation and useful guidance relevant to the management of the service. The registered manager ensured they received updates from the Medicine and Healthcare Products Regulatory Agency (MHPRA). The information obtained was used to update the service's procedures. All the policies that we saw were reviewed annually, were up to date with legislation and were fully accessible to staff.

Members of staff confirmed they were aware of the service's whistleblowing policy and that they were able to report any concern they or the people may have to the registered manager. They told us that they had confidence in the registered manager and deputy manager's response.

Members of staff confirmed the registered manager was supportive and understanding of the challenges they encountered. We saw that the manager was included in the staff rota and spent time delivering care for people. The manager told us, "I like to be 'on the floor' and work alongside the care staff; I do not want to be one of these managers who sit in their office and lose touch with the residents and what is happening". Two members of staff told us, "This manager is brilliant, he understands the staff and the residents", and "He is a leader but he is also one of us". This interaction promoted good communication and mutual respect between the registered manager and the members of staff. It also enabled the registered manager to remain aware of the day to day culture in the service, including the attitudes of staff.

Monthly residents meetings were held and recorded. We looked at recent minutes of the meetings and saw people had commented positively on the new menus and had made suggestions that were followed up. For example, a person expressed the wish to have spicy food and another 'no peas', and we saw their menus had been altered to reflect this. Yearly satisfaction questionnaires were sent to stakeholders and people's relatives and representatives. We saw in the last survey which was carried out in October 2014 that a relative had commented on the lack of private areas. This had led to the redistribution of space in the dining room to create a quiet area for people to relax in.

Good

Is the service well-led?

Staff meetings were held every monthly or sooner when needed. We looked at minutes of these meetings and found that staff contributed to the agenda and spoke freely. A system of communication book and handovers ensured vital information was passed on between shifts. Staff's code of conduct and jobs description were discussed at each supervision to ensure they understood what was expected of them.

There was a system of quality assurance in place to monitor the overall quality of the service and identify the needs for improvement. A regional operations manager inspected the service every month to check compliance with regulations and make recommendations. We looked at their last three reports and found they were consistently comprehensive. They included an inspection of the premises, audits of all aspects of the service carried out in rotation, and observations of staff and people to ensure good standards were maintained. For example, the last audits included health and safety, medicines, finances, staff files, people's records, the completion of documentation and satisfaction surveys. The reports also included an account of discussions with the staff and people and identified what might have been missed. For example, we saw a recommendation for a best interest meeting to be held and for a vital piece of information concerning a person to be included in their care plan. Recommendations were followed up and actioned within a set time frame. We saw records of new initiatives that had been discussed by the regional operations manager and the manager. For example, the regional operations manager had commented, "X (the manager) felt some of the templates need improving and will adapt handover forms and daily diaries to improve their fitness for purpose". This had been implemented. The manager told us, "This system works well as it is important to get a different perspective and a fresh pair of eyes".

The manager completed a weekly environmental check, a weekly report on all incidents and accidents and a yearly quality assurance report on all aspects of the service. Findings were analysed to identify where and how improvements could be made. For example, as a result of these monitoring checks, one to one support had been implemented to ensure the management of a particular interaction between two people.