

# MNP Complete Care Group

# Sandgate Manor

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

Sandgate Manor is a service for up to 25 people with learning disabilities and /or autistic spectrum disorder who may also have physical disabilities. The service comprises of a large main house that houses 19 people and three lodges that house three people. At the time of our inspection there were 22 people living at the service.

Sandgate Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service also employed a 'home manager' and a 'trainee manager' as part of the management team working under the registered manager.

People received their medicines when they needed them from staff that had been trained and competency checked. However, there were no separate protocols in place for 'as required' medicines. You can see what action we told the provider to take at the back of the full version of the report.

Quality auditing systems had not been effective in highlighting issues we found at this inspection such as with 'as required' medicines not having the required paperwork and the lack of an accessible complaint policy. You can see what action we told the provider to take at the back of the full version of the report.

People were kept safe from abuse and harm Staff had received training and knew how to report suspicions around abuse. Risks to people were minimised through the use of effective control measures. There were sufficient numbers of staff deployed to meet people's needs and ensure their safety.

Staff understood the best practice procedures for reducing the risk of infection and audits were carried out to ensure the environment was clean and safe. The service used incidents, accidents and near misses to learn from mistakes and drive improvements.

People had effective assessments prior to a service being offered. Care outcomes were planned and staff understood what support each person required. Staff were trained in key areas and had the skills and knowledge to carry out their roles. People were supported to receive enough to eat and drink; staff used food and fluid charts to record intake for people at risk of malnourishment or dehydration.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful and the least restrictive option.

The service worked in collaboration with other professionals such as district nursing and people's GP's to ensure care was effectively delivered. People maintained good health and had access to health and social care professionals. Environments were risk assessed to ensure people were safe in their homes and staff could work without the risk of danger.

Staff treated people with kindness and compassion in their day to day care. Staff knew people's needs well and people told us they valued and liked their care staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to be as independent as safely possible.

People received a person centred service that was supportive of their needs. People's needs were fully assessed and care plans ensured that personal details were carried through to care delivery. Staff were open to any complaints and understood that responding to people's concerns was a part of good care. There was a complaints policy and form, though there was not an accessible format available to people. We have made a recommendation about this in our report.

End of life care had been planned for people who wished to do so. The service had end of life care plans but these did not make it clear how people would be supported to prepare for the end of life phase. We have made a recommendation about this in our report.

There was an open and inclusive culture that was implemented by effective leadership from the registered manager. People and staff spoke of a 'family' culture that was caring. People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice and of working collaboratively with other professionals and health providers and this was done in an open and honest way.

This is the first time the service has been rated as Requires Improvement.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** 

Sandgate Manor was not consistently safe.

People who received 'as required' medicines did not have all necessary information recorded. Other medicines had been stored and administered safely.

People were protected from the risk of abuse and staff understood their role in reporting concerns.

Risks to people, staff and others had been assessed and recorded and control measures were effective in reducing potential harm.

There was a sufficient number of staff to ensure that people's needs were consistently met. Safe recruitment procedures were followed in practice.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Lessons were learned when things went wrong: accidents and incidents were investigated and learning fed back to staff.

### Is the service effective?

**Good** 

Sandgate Manor was effective.

People received assessments that ensured that goals and targets were set in care plans and worked towards.

Staff received effective training to meet people's needs. An induction and training programme was in place for all staff and staff had effective supervision and appraisal.

People were supported to eat and drink enough to maintain good health and this was monitored where needed by staff.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

People were supported to remain as healthy as possible and had

access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice. Staff understood the importance of gaining consent from people before they delivered any care.

### Is the service caring?

**Good** ●

Sandgate Manor was caring.

People were supported by staff who were caring and respected their privacy and dignity.

People were involved in the development of their care plans and their personal preferences were recorded.

Staff had access to people's likes and personal histories and used the information to support people in a way that upheld their dignity and protected their privacy. People were supported to maintain their independence.

### Is the service responsive?

**Requires Improvement** ●

Sandgate Manor was not consistently responsive.

A complaints policy and procedure was in place and available to people but there was no accessible version for people who could not read.

Where people received end of life care this was provided sensitively. However, people did not have comprehensive end of life care plans.

People's needs were assessed, recorded and reviewed.

People received personalised care and were included in decisions about their care and support.

### Is the service well-led?

**Requires Improvement** ●

Sandgate Manor was not consistently well led.

The systems for assessing, monitoring and developing the quality of the service being provided to people had not highlighted shortfalls we found during the inspection.

There was an open culture where staff were kept informed and

able to suggest ideas to improve the service.

Staff understood their responsibilities and knew who the management team were, and felt able to approach them.

The views of people and others were actively sought and acted on.

The service continuously learned and improved and staff were given opportunity to progress.

The service worked in partnership with other agencies.

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# Sandgate Manor

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 and 29 November 2017 and was unannounced. Inspection site visit activity started on 28 November and ended on 29 November 2017. It included direct observation of care and support, interviews with people, their relatives and staff employed by the service, and review of care records and policies and procedures.

Before the inspection we looked at information we held about the provider. On this occasion we did not send a Provider Information Return to be completed. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of two inspectors and one expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke with the registered manager, deputy manager, trainee manager, two senior carers, five care staff, nine people and three people's relatives. After the inspection we spoke with a health and social care professional who is in regular contact with the service. We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

This is the first time the service had been inspected under their new registration.

# Is the service safe?

## Our findings

People living at Sandgate Manor, and their relatives, told us that they felt safe at the service. One person told us, "I feel safe and cared for by all the staff. I press my buzzer if I need help." Another person commented, "I like living here. I feel safe when I go out with a carer. I don't feel safe on my own [outside]; I might fall over or get lost. I feel safe no one can get in." A third person said, "I feel safe living here. If I need help I press my call button and they come in a reasonable time. I don't like to buzz, but I know I can." Comments from relatives included, "We feel he is safe living here. He is supported in a safe way when he is moved around from chair to bed etc. He is happy here" and "My son has lived here 20 years. I find the place fine. The staff are helpful; it is as close as it can be to him living at home."

Some people had been prescribed as when required (PRN) medicines. Although information around people's PRN medicines had been written on to the MAR chart, there were no separate PRN protocols to inform staff when to give PRN medicines, how much of each medicine people could have and the reasons for administration. The use of MAR charts to record PRN information meant staff did not have detailed and person centred guidance on when and how to give people medicines they required 'as and when'.

The failure to have in place detailed guidance for staff on the administration of PRN medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe medicines administration systems in place and people received their medicines when required. The service used a monitored dosage system where tablets arrived from the pharmacy pre-packed and in a separate compartment for each dosage time of the day. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted correctly, meaning that audits of medicines were being conducted accurately and regularly. MAR charts had been signed correctly to indicate that people had received their medicines. Medicines were stored safely in lockable cabinets, within a locked room, including medicines that required additional security. There were separate storage for people's topical creams and lotions and each item had a label on to indicate when it had been opened. Good administration practices were observed and staff checked the medicine, person, route and dosage before offering the tablets to people with a glass of water.

Some information around safeguarding was not available on the first day of the inspection. The service did not have a copy of the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. However, the registered manager had made a copy available to all staff by the end of our inspection. The registered provider had a safeguarding policy, but this conflicted with the local authority policy relating to the reporting and investigation of safeguarding concerns. A delay in reporting concerns could occur if staff members had followed the provider's policy as they could have reported incorrectly. We discussed this with the registered manager, who reported this to the senior management team for it to be actioned. Subsequent to our inspection this issue had been rectified.

Staff we spoke with were aware of the different types of abuse, including newer definitions of abuse such as



modern slavery. The registered manager had been notifying CQC of safeguarding incidents when they occurred. The provider's safeguarding policy and induction programme ensured that people were protected from discrimination and that principles of diversity and inclusion were understood by staff.

Risk assessments were effective in keeping people safe from harm and control measures reduced potential hazards. People had general risk assessments in place for areas such as travelling on a minibus, medicines, finances and swimming. Where people had been assessed as being at risk of falls, or being at risk of injury through impairments to their mobility, they had received a moving and handling assessment. Staff knew how to support people to move safely. For example: One person's moving and handling assessment had identified the issues the person had when walking and described in detail the recommended procedure for moving the person and how many staff were needed for each type of moving and handling task. People had care plans in place for behaviours which may challenge others in order to keep them safe. These plans looked at the underlying causes of certain behaviours and gave staff guidance on how best to support people. There were up to date safety certificates for gas appliances, electrical installations, portable appliances, lift and hoist maintenance. The registered manager ensured that general risks such as slips, and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. Each risk assessment identified the risk and what actions were required of staff to reduce the hazard. The fire risk assessment was effective and up to date. Fire drills were happening and records showed that this included night time drills when staffing levels were lower. Staff were aware that each person had a personal emergency evacuation plan (PEEP) for the risk level associated with evacuating people safely in the event of a fire. A copy of all PEEP's was retained in an emergency folder near the fire alarm panel and were personalised and detailed sufficiently for staff to keep people safe in the event of an emergency.

There were sufficient staff deployed to meet people's needs and to keep them safe. The staffing levels were worked out on a three to one ratio based on people's assessed and funded needs. Some people at the service had higher needs and where this had been identified they were receiving additional one to one staff support. We checked the services duty rota and saw that the levels of staffing identified by the registered manager as being required to operate the service safely had been provided. We observed that there were sufficient staff to meet people's needs and keep them safe and there were staff members available throughout the day. People, their relatives and staff members told us that they thought there were sufficient staff to meet people's needs. One person staff member commented, "On a normal day there are enough staff. We work well as a team together, and it's organised and everything gets done. In between personal care and breakfast we spend time with residents and by 11 in the morning we're with the residents doing activities."

Recruitment processes were robust and safe recruitment procedures were followed. Recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible.

People were being kept safe against the risk of infection by the prevention and control of infection hazards. Infection control training had been evidenced for all staff and this training had been competency checked by the registered manager. The service was clean and hygienic during our inspection. There was an infection control checklist that had recently been implemented and the trainee manager had been made an infection control champion with responsibility for managing infections, and alerting the correct external agencies to

concerns that affect people's health and wellbeing. There was an appropriate supply of personal protective equipment throughout the service and we saw that staff used this as needed. Suitable hand washing facilities were available and reminders about safe hand washing were displayed. There was a large and well organised laundry that enabled staff to keep clean and dirty linen separate to reduce infection and cross contamination risks. The service used the 'Safer Food Better Business' scheme. Safer Food Better Business is a food safety pack produced by the Food Standards Agency to help small catering businesses comply with food hygiene regulations. Temperature checks had been carried out for the fridge and freezer and the temperature of food served to people. There were cleaning charts completed for the kitchen and dry stores area and these were clean.

Accidents and incidents had been recorded and investigated by the registered manager. We reviewed a sample of incident and accident reports and saw that any issues had been recorded and an action plan generated. For example, one person caused an injury to another person due to an issue with the controls on their motorised wheelchair. An action plan detailed the input sought and received from wheelchair services and additional checks of the chair that staff were making. This had been effective in reducing the risk posed to people.

## Is the service effective?

### Our findings

People told us that they felt the service was effective in meeting their needs. They told us staff had the necessary skills to provide the care they needed and that they supported them to access health services as needed. One person said, "The food is nice here. I like the spaghetti bolognese. We often have the same vegetables, broccoli and cauliflower." Another person told us, "I choose my own food and order it online. The staff cook it for me. Some are better than others at cooking." One relative told us, "X had broken his foot, and they found out he has osteoporosis. The staff let us know, they give us a ring if there is a problem. He enjoys his food here. He was underweight, they gave him 2 breakfasts and he put on weight." A second relative commented, "The chef is very good here. My family member has a soft diet. The chef tries to cook food he likes".

People's needs were assessed and their care had been planned to achieve good outcomes. There were assessments of people's needs prior to a service being provided. The assessments identified a range of people's needs from which support plans were drawn up and worked to accordingly. For example, each person had a baseline assessment of needs for daily living. This assessment covered areas such as waking and sleeping routines, food and drink, general healthcare and mobility. We reviewed the assessment for a person who recently moved in for respite care. The assessment covered the person's religion, culture and beliefs. It identified that they liked to attend a specified place of worship and that they celebrated religious festivals.

Staff told us they had the training and skills they needed to meet people's needs. One staff member commented, "The training is really good and some of it is really interesting. I had epilepsy training which was really useful and showed us how to give rescue medication and what to do in the event of a seizure." We reviewed the training matrix and found that staff had access to a range of courses to enable them to carry out their role. New staff had an induction when they joined the service. This included undertaking modules from The Care Certificate. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. A manager taught the units and a team leader competency checked new staff. Newly recruited staff were subject to a probationary period before their employment was confirmed permanently. Some courses such as medicines were competency checked to ensure that staff members had understood their training. Staff received effective, regular supervision and appraisal that had been organised through an annual supervision planner. We saw examples where staff members had requested extra supervision. Staff received an annual appraisal and were given targets to achieve for the coming year and asked to rate their own performance.

People received enough food and drink to meet their needs and maintain good health. One person told us, "The food is really good here. We always have enough to eat and it tastes good. People received adequate hydration. We saw that drinks were made readily available to people throughout the day and people were encouraged to take drinks regularly. One staff member commented, "People definitely have enough to drink. One staff member is dedicated to do a fluid round for every person at mealtimes and in between as well." The service used food and fluid charts for short periods where there were concerns about the amounts people were eating or drinking. We saw weights records for one person who had been prescribed a dietary

supplement. Another person had an eating and drinking guide which directed staff to cut food up in a certain way and be mindful of the person's continence needs prior to mealtimes. The person also had a dairy allergy and this was managed in the plan with very clear guidelines for staff for all stages of eating and drinking.

Staff worked together to ensure that people received a consistent and person-centred support when they were referred to, or moved between different services. The registered manager explained to us how the referrals process usually worked, with referrals coming from social services with a manager then attending the referrals' address to complete an assessment. During the assessment a copy of the service user guide and information pack was given to the person so they would have information about the service. Where the referral had been from another care provider there had been a formal meeting to hand over documents and include any information in the new care plan. The registered manager described how people had moved from Sandgate Manor to independent living schemes. One person was supported by Sandgate Manor staff for three weeks after their move to ensure that the new support package was consistent with their needs.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. Care plans clearly demonstrated that a wide range of professionals were involved in people's care. For example, one person's care plan referenced a neurologist, epilepsy nurse, GP, optician, and learning disability nurse. People with a diagnosis of epilepsy had a seizure protocol in place to explain to staff how to safely manage people's seizures. People were monitored effectively and where there had been changes in people's presentation or diagnosis healthcare services were contacted and people were seen by professionals. One person had experienced heightened seizure activity and had been referred swiftly to the neurologist for treatment. This was typical of the responsive service that people received in relation to their health needs.

People's individual needs were met by the design of the premises and they were able to have their say on the environment in which they lived. People's bedrooms were their own 'space' and people could choose their own decoration including furnishing and flooring of their choice. There were overhead hoists in essential areas such as some bathrooms, and mobile hoists were used in other areas and a shower trolley in a wet room. This gave the service the flexibility to meet a range of people's differing needs and for people to be enabled to do as much for themselves as possible as the environment was tailored to their needs. There was a cyclical decorations programme and people were involved in choosing colour schemes. The main building at Sandgate Manor had wide corridors for wheelchairs to manoeuvre easily and external pathways were graded and wide enough for wheelchair use so that people could access all areas of their garden.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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. People's right to make decisions was promoted and the principles of the MCA were adhered to. We noted that some MCA assessments were not decision specific. We discussed this with the registered manager who agreed this was not right. By the end of our inspection these had been put right and individual MCA assessments with best interest meetings for people who lacked capacity for specific decisions had been completed.

## Is the service caring?

### Our findings

People, and their relatives, told us they felt the staff were caring and treated them kindly. One person told us, "I feel safe and cared for by all the staff." Another person commented, "The staff are kind and caring and I like living here." One relative told us, "The staff are very good with him. They make sure he sends cards to family members on their birthdays, and Mother's and Father's Day cards [abroad] where his parents live. The staff make the effort to find out which day Mother's and Father's Day are [abroad], as it is different from the UK. He flies out to see his parents. The staff look after him well. It is a pleasant atmosphere when we are all together [abroad]. The staff are like part of the family".

Staff had built up positive and caring relationships with people they were supporting. Staff knew how to communicate with different people and where people had a communication need this was explained in their care plan. Peoples care plans described the best way for staff to communicate with them. For example, for one person staff were advised that a hug on greeting and departure was a positive act. Another person's care plan described how they were able to understand worries and concerns and how staff should support them to do this. Staff knew how to communicate with people to achieve good outcomes for them. One staff member told us about one person who had previously struggled with anxiety who had been supported gradually to engage with community activities and gain voluntary employment which they were now enjoying.

During our inspection we saw people interacted well with staff and staff supported and engaged with people. At lunchtime, the chef came into the main dining area to ask people if they were ready for lunch before it was served. There were jugs of squash on the table for people to drink, however people were able to have whatever they wanted and one person had a can of soda. People were asked where they would like to sit and could sit wherever they chose. Some people sat at the main dining table however other people chose to sit in their wheelchairs with a tray in front of the television. When staff brought people their meals they asked them if they would like it cut up before they did so. Staff talked to people about their meals for example they said things like "Mmm, that smells good doesn't it" and "Doesn't this look lovely".

People were supported to express their views and be actively involved in making decisions about their care and support. We observed staff interacting with people and chatting with them about their day which included asking them what they would like to do later. Some people were sat with a communication support worker at the computer working on their 'talk about me' books which were photo books containing photos of people taking part in activities that they could then show to relatives and use as talking points. After lunch, the chef came out of the kitchen and asked people for feedback on the lunch. The chef asked people if they had enjoyed it and if there was anything else they would have liked. Staff showed people options of dessert so that they had the option of deciding whether they wanted some or not after seeing it so they knew exactly what it was.

Peoples' care plans promoted their ability to be involved in their care and support. One person's care plan stated in detail exactly how they needed to be supported during personal care. It stated exactly what equipment the person required and when and how to use it so that the person received the care and

support in the specific way they wanted. Staff members were able to recognise when people needed and wanted support from them and were responsive to this need. One staff member said, "I know if one particular person wants support and can recognise the signs: they look 'down' or sad. When that happens I start a little discussion with the person and find out what's wrong and how I can help them."

People were supported to work towards independence and achieve their goals in a safe and nurturing manner. The service had supported a person who was planning to move out and live with their partner. They were supported to look at different potential properties. In order to prepare for this the service worked with both people and their families and the local authority to enable the person's partner to stay with them for a month as a visitor. This enabled the person and their partner to set goals and decide what their future plans would be.

People's right to privacy and dignity was respected. People felt that they were treated kindly and with respect. One person told us, "The staff speak kindly to me and knock on the door before they come in. I need help with the shower. The staff ask me what help I want. I am encouraged to do things on my own". Another person said, "I like living [here], it is the best of both worlds. I can have time on my own, and company if I want. I am encouraged to be independent. I order food online. I was asked to do a menu plan, but I didn't want to in case I changed my mind. The staff respected that." One staff member commented, "We always close the curtains and doors and cover people during personal care. We make sure the person looks tidy and clean if they cannot do it for themselves." There were three people who lived in separate lodges where they were fully contained including a kitchen, bathroom, bedroom and lounge area. Staff provided support for them five hours each day, some of which could be used for outings. However, the people living in the lodges were able to come and go as they pleased and they could choose when they mixed with people in the main house.

## Is the service responsive?

### Our findings

People and their relatives told us that the staff were responsive to their needs and requests. One person said, "I go to Network on a Thursday and do art and craft in the morning, and chat in the afternoon. I would like to do cooking. I have a fridge in my room and can help myself to a drink." Another person commented, "I would like to live in the community with support. The Occupational Therapist is coming to assess me. I would like to have my own place with my boyfriend." A third person said, "I go out with the staff to Canterbury, Ashford and Hastings. I go shopping, which I like. I like bird watching. I have a bird feeder in the garden, but it is just the same birds that keep coming." One relative told us, "Our family member goes out to appropriate activities such as hydrotherapy and sensory. The staff ask him before they do anything with him. He can make himself understood.

There was a complaints policy and log in place. The service did not have a formal process for recording compliments received; however, we were told that they had asked people who had verbally given them compliments if they could send them something in writing that they could keep. There were two different complaints policies in the complaints folder and it was not clear which was the current one in use. We were told that each person had a copy of the complaints policy in their wardrobes. Some people who were unable to read would not have had a copy of the complaints policy that they understood as the service did not provide a complaints policy in an accessible format such as pictorial, large print or easy read. The registered manager told us that staff usually read the complaints policy to the people at the service but we did not see any documented evidence of this at the inspection. The service had recorded six complaints in the last 12 months. We reviewed two of these and saw that each complaint had been investigated and a response given to the person who complained. Where complaints involved staff members, we saw that they had received supervision with a manager to discuss the complaint. There was an overview of any actions taken as a result of complaints on the complaint record so that they could be viewed at a glance. Staff were aware of the complaints process and knew how to support people to make a complaint if needed.

We recommend that the registered provider reviews the complaints procedure to ensure that it is available in accessible format if people require them.

People were able to be supported at the service for end of life care. One staff member told us, "I always make people comfortable at the end of their life; always swapping new pillows in. It's about making the person as comfortable and happy as they can be. We also get support from palliative nurses who visit here and provide extra medication." Some people had consented to do not attempt resuscitation (DNAR) with their GP or consultants. There was currently no one at the service who was receiving end of life care. We reviewed two care plans but did not see any information about how to support the person to prepare for the end of life. The registered manager agreed to work towards introducing a holistic end of life care plan.

We recommend that the registered manager reviews the end of life care plans to make clear how people will be supported to prepare for the end of life.

People's care plans showed they were supported with their physical health needs: People had received



health checks within the last 12 months which provided them with individual advice on how to improve their health and wellbeing such as by following a balanced diet or reducing cholesterol. There were advice and guidance sheets for staff to follow to support people according to the recommendations given. People were supported to attend appointments with other healthcare professionals such as hospital appointments and for flu immunisations. There was guidance in people's care records for people around their nutritional needs such as if they required a soft diet or to have their food cut up into small pieces. There were instructions about how people should be supported at mealtimes for example, whether they needed prompting or assistance with eating.

People were supported in line with the guidance in their care plans. People's care plans contained risk assessments for different aspects of their care and support needs. There was guidance in people's care plans for staff to follow when moving them or using equipment such as hoists to support them. The guidance contained photos of the person being moved or supported in a step by step guide which reflected how people were comfortable and able to be supported safely. People had access to a wide range of activities. One relative told us, "My family member goes bowling with the other residents. He goes to the gym, gives anything a go. He is unable to be independent. I respect the decisions the staff make about his care and wellbeing." We saw that people had been to several outings recently and that there were festive outings planned for Christmas such as shopping in London and to other festive activities.

People were able to choose what they did on a daily basis. On the first day of our inspection one person was going Christmas shopping with a member of staff. People were supported to go on trips and holidays which they chose based on their interests. People were asked what they wanted to do and staff were able to be flexible if people wanted to do something different to the pre-planned activity. We observed a member of staff asking a person where they wanted to go shopping so that the activity was focused on what the person wanted. People were able to participate in activities as a group but were also supported to take part in individual activities or one to one time that was tailored to their needs. One person had an individual physiotherapy programme which we observed the person carrying out with a member of staff.



## Is the service well-led?

### Our findings

People and their relatives told us they felt the service was well led. One person told us, "The house manager does a good job. I don't like doing the questionnaires they give us as I worry I may say the wrong thing, even though [name] says I can't say anything wrong." Another person commented, "I would tell the main managers, if there was a problem." One relative told us, "Communication is good between myself and the managers. They respond to my suggestions and are open to ideas. We are sent a survey every few months." A second relative commented, "If we are not happy with a situation we would talk to the care manager, but we also speak to the keyworker. The manager is fun, proactive, but realistic about people's expectations."

There was a governance framework in place to ensure that quality monitoring was reviewed and regulatory requirements were managed correctly. However, the quality monitoring system was not wholly effective: it had not identified issues found during this inspection such as the safeguarding policy needing to be aligned with the local authority policy, some MCA assessments not being decision specific and the complaints policy not being in an accessible format.

The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service. This is a breach of Regulation 17 of the HSCA Regulations 2014.

There was an open and inclusive culture in the service. The service was person centred and each person was supported according to their own needs. There was a registered manager employed at the service and they had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. We saw that the trainee manager had used supervision to challenge one comment made by a member of staff that could have been interpreted in a negative way. The willingness of the management team to discuss working practices and language ensured there was an open culture in the service. The management team ensured that staff were supported and felt valued by having a rota system whereby there was always one manager available during the day and on-call. The registered manager commented, "Staff get the support they need: they can come in to the office and they have regular supervisions. Communication is key and our goal is to look after residents as though they were our families and staff describe the service as a big family." Inclusion and diversity was being promoted by the organisation and was an important part of staff induction. New staff worked through the Care Certificate Equality, Diversity, Inclusion and Discrimination module.

There were external audits for areas such as medicines and internal audits that covered areas such as infection control and health and safety amongst others. These audits were effective in highlighting areas for improvement and allocating responsibilities to people within a given timeframe for their completion. The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that no incidents had met the threshold for Duty of Candour.

This is so that people, visitors and those seeking information about the service can be informed of our judgments.

The registered manager was given good support from partners on the registered providers' board. One partner regularly visited the service to conduct monthly checks and audits. In October 2017 there had been an audit of supervisions which had generated actions that had been completed. There was a managers meeting with the heads of all the organisations services that the registered manager attends. One trustee had weekly contact with the registered manager to update and supervise them.

People, their families and staff members were involved in the service and regular feedback was sought through questionnaires. Questionnaires had regularly been sent out to people, their relatives and other stakeholders and to staff members. The feedback from these questionnaires had been collated and tracked through to an action plan to ensure the quality of the service improved. Comments garnered from the feedback included practical suggestions such as ways to mop one bathroom floor to avoid excessive water being left on it. There were regular 'residents meetings' where people could have a voice in how their service was being run. In one meeting that we reviewed we saw that the registered manager and one of the trustees had both attended and one person was given the role of spokesperson. There had been a discussion about a particular incident and the registered manager had apologised to people for any disruption. People chose a Christmas box advent calendar where each person chose a local charity and donated a box of gifts to them. Other people booked outings and trips to the local community such as Christmas shopping trips and trips to a reindeer centre.

Staff were actively involved in developing the service through regular staff meetings where they were encouraged to make suggestions. Suggestions made recently included how to enable one person with high risks factors to ride their bike safely and only having one staff bring food from the hot trolley to the table. People' relatives and wider support circle were encouraged to be involved with the service and people accessed the local community. The registered manager told us, "A Children In Need fundraiser was held in memory of an ex-resident and lots of family and friends came in. We have people who attend an outside community group, people use the library, and one person does a McMillan coffee morning." Events such as Halloween, royal weddings, and Easter are celebrated with parties where the wider community are invited to attend.

The service was continuously learning and improving and learning was shared with staff members. We discussed with the registered manager how learning was identified and cascaded to staff members and were show some case studies. One incident had occurred where a staff member had their hair pulled out and had been an instigator for the introduction of ABC charts. ABC charts are an observational tool that allow staff to record information about a particular behaviour and to better understand what the behaviour is communicating. In another incident a psychologist came and spoke to the staff team about issues around capacity and the underlying reasons for certain behaviours. It had been identified that staff had been unintentionally re-enforcing one person's behaviours. Strategies had been identified for staff to implement and these had reduced the number of incidents.

The registered manager had a good working relationship with the local authority statutory services. The registered manager told us, "We have support from two directions as some residents are under the physical disabilities team and some are under the learning disabilities team." There was regular input from the local authority occupational therapy (OT) department and there was a piece of work underway during our inspection where the OT was helping the service to introduce a special splint for someone with a fractured limb who couldn't have a standard splint due to other diagnoses. There were good working relationships with the physiotherapists from the local authority teams and they had been in the service recently to trial a

new walking frame for one person. When a person experienced changes, such as coming out of hospital after a long admission, the service had involved the speech and language therapy team to assess their diet and swallow.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The registered provider failed to ensure that detailed guidance was available to staff on the administration of PRN medicines.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service