Broadham Care Limited

Gresham 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

This inspection was carried out on 07 July 2015 by one inspector and an Expert by Experience. It was an announced inspection. Forty-eight hours' notice of the inspection was given to ensure that the people who lived in the service were prepared to receive unfamiliar visitors. Not all the people living at the service were able to express themselves verbally. Some people used specialised equipment to express themselves and others used body language.

Gresham House provides support and accommodation for up to ten adults with a learning disability. There were ten people living there at the time of our inspection.

There was a 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 how to protect people from abuse and harm. They were aware of the procedures to follow in case of abuse or suspicion of abuse, whistle blowing and bullying.

Risk assessments were centred on the needs of the individual. They included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how risks of re-occurrence could be reduced.

There were enough qualified, skilled and experienced staff to meet people's needs. Staffing levels were calculated according to people's changing needs and ensured continuity of one to one support. Thorough recruitment practice was followed to ensure staff were suitable for their role.

Staff were trained in the safe administration of medicines. Records relevant to the administration of medicines or the supervision of medicines were monitored. This ensured they were accurately kept and medicines were administered to people and taken by people safely according to their individual needs.

Staff knew each person well and understood how to meet their support needs. Each person's needs and personal preferences had been assessed before care was provided and were continually reviewed. This ensured that the staff could provide care in a way that met people's particular needs and wishes.

Staff had completed the training they needed to support people in a safe way. They had the opportunity to receive further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions to ensure they were supported while they carried out their role. They received an annual appraisal of their performance and training needs.

All care staff and management were trained in the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They were knowledgeable about the requirements of the legislation. People's mental capacity was assessed and meetings were held in their best interest when appropriate.

Staff sought and obtained people's consent before they provided support. When people declined or changed their mind, their wishes were respected.

Staff supported people with their planning of menus, activities and holidays. They ensured people made informed choices that promoted their health. Staff knew about people's dietary preferences and restrictions.

People told us that staff communicated effectively with them, responded to their needs promptly and treated them with kindness and respect. People were satisfied with how their support was delivered. Clear information about the service, the management, the facilities, and how to complain was provided to people. Information was available in a format that met people's needs.

People were referred to health care professionals when needed and in a timely way. Personal records included people's individual plans of care, likes and dislikes and preferred activities.

The registered manager and the staff's approach promoted people's independence and encouraged them to do as much as possible for themselves and make their own decisions. Comments from relatives included, "There is such a family feel about this place, and the staff make it home."

People's privacy was respected and people were assisted in a way that respected their dignity and individuality.

People's individual assessments and care plans were reviewed regularly with their participation or their representatives' involvement. People's care plans were updated when their needs changed to make sure people received the support they needed.

The provider took account of people's views and these were acted upon. The provider sent questionnaires regularly to people's legal representatives. The results were analysed and action was taken in response to people's views.

Staff told us they felt valued and supported under the manager's leadership. The manager notified the Care Quality Commission of any significant events that affected people or the service. Comprehensive quality assurance audits were carried out to identify how the service could improve and action was taken to implement improvements.

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?
Good

The service was safe.

Staff were trained in the safeguarding of adults and were knowledgeable about the procedures to follow to keep people safe.

Staff knew about and used policies and guidance to minimise the risks associated with people's support. Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to safely meet people's needs.

Thorough staff recruitment procedures were followed in practice. Medicines were administered safely.

Is the service effective?
Good

The service was effective.

All staff had completed essential training to maintain their knowledge and skills. Additional training was provided so staff were knowledgeable about people's individual requirements.

The provider was meeting the requirements of the Mental Capacity Act 2005.

People were referred to healthcare professionals promptly when required.

Is the service caring?
Good

The service was caring.

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

Information was provided to people about the service and how to complain. People were fully involved in the planning of their support and staff provided clear explanations to support people's decisions.

Staff respected people's privacy and dignity.

Is the service responsive?
Good

The service was responsive.

People's needs were assessed before they moved into the service. People's support was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when people's needs changed.

People knew how to complain and people's views were listened to and acted on.

Is the service well-led?
Good

The service was well led.

There was an open and positive culture which focussed on people. The manager sought people and staff's feedback and welcomed their suggestions for improvement.

Staff had confidence in the manager's leadership and response when they had any concerns.

Summary of findings

There was a system of quality assurance in place. The registered manager and the Operations and Compliance Director carried out audits of several aspects of the service to identify where improvements could be made.

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

This inspection was carried out on 07 July 2015 and was announced. We gave notice of our inspection to ensure people were prepared by staff who explained the purpose of our visit. The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience who took part in the inspection had specific knowledge of caring for people with learning disabilities.

The manager had not received a Provider Information Return (PIR) at the time of our visit. The PIR 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 gathered this information during the inspection. Before our inspection we looked at records that were sent to us by the manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports.

We spoke with seven people who lived in the service and two of their relatives to gather their feedback. We also spoke with the registered manager, the deputy manager and five members of care staff. We consulted two local authority case managers who oversaw people's care in the service. We obtained their feedback about their experience of the service

We looked at records which included those related to ten people's care, staff management, staff recruitment and quality of the service. We looked at people's assessments of needs and care plans and observed to check that the support provided was delivered consistently with these records. We looked at the satisfaction surveys that had been carried out. We sampled six of the services' policies and procedures.

At our last inspection on 26 July 2013 no concerns were found.

Good

Is the service safe?

Our findings

When we asked two people whether they felt safe living in the service, they replied "Yes", and "It feels good". Two relatives told us, "This is a very safe environment for my family member to live" and, "The young people living there could not be safer".

There were sufficient staff on duty to meet people's needs. People's individual needs were assessed and this information was used to calculate how many staff were needed on shift at any time. Before people moved into the service, the registered manager completed an assessment to ensure the service could provide staffing that was sufficient to meet their needs. This ensured staff were available to respond promptly to people's needs and promote their safety.

Our observations indicated that sufficient staff were deployed in the service to meet people's needs during daytime and at night time. One member of staff was allocated to support two people during the day. Two waking staff were in attendance during the night. The registered manager determined the number of staff deployed according to people's dependency levels. Staff rotas were planned in advance to ensure sufficient staff were deployed. We saw that the staff shift pattern ensured continuous cover to respond to people's needs. Additional staff were deployed to meet people's individual requirement when necessary, for example for one-to-one support, activities in the community and medical appointments. The provider told us that the service would be welcoming two new people in October and that staff would be increased to meet their needs. The registered manager told us, "Our existing staff manage to cover each other's absence; we rarely use agency staff but if we do we insist on staff who are already familiar with the service and the residents."

The registered manager reviewed people's care whenever their needs changed to determine the staffing levels needed, and increased staffing levels accordingly. When a change of circumstances had required additional monitoring, this had been provided. For example, an additional member of staff had been deployed when a person had displayed signs of anxiety and had needed one to one support over four days. This ensured there were enough staff to meet people's needs.

People's medicines were managed so that they received them safely. The service held a policy for the administration of medicines that was regularly reviewed and current. Staff had received appropriate training in the recording, handling, safe keeping, administration and disposal of medicines. The registered manager carried out competency checks to ensure staff remained competent in the administration of medicines. People's needs and their wishes relevant to their medicines were assessed and reviewed. Medicines were kept at the recommended temperature to ensure they remained safe to use. The medicines administration records (MARs) were checked daily at the end of each staff shift and weekly to ensure no omissions or errors had occurred. Monthly audits of medicines were carried out to check medicines were administered safely. When shortfalls had been identified, such as an omission, disciplinary action had been taken and staff had undertaken refresher training. This system ensured that people received their medicines safely.

The service held a policy on the safeguarding of adults that had been updated to reflect recent changes in the Kent and Medway Safeguarding protocol. Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. Staff training records confirmed that their training in the safeguarding of adults was annual and up to date. The members of staff we spoke with demonstrated their knowledge of the procedures to follow to report abuse and they knew how to use the whistle blowing policy should they have any concerns. The whistle blowing policy was displayed in the office for staff to refer to. One member of staff said, "We would raise the alarm straight away". The registered manager told us, "All the staff are made aware of the importance to voice any concerns and this is discussed at each team meeting and at each one to one supervision sessions." This ensured that abuse or suspicion of abuse could be reported without delay to keep people as safe as possible.

We checked staff files to ensure safe recruitment procedures were followed. Recruitment procedures included interview records, checking employment references and carrying out Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff had a criminal record or were barred from working with adults. Gaps in employment history were explained. All staff received an appropriate induction and shadowed more experienced staff until they could demonstrate a

Good

Is the service safe?

satisfactory level of competence to work on their own. New recruits were subject to a six months' probation period before they became permanent members of staff. They worked towards acquiring the 'Care Certificate' that was introduced in April 2015. This care certificate is designed for new and existing staff and sets out the learning outcomes, competences and standard of care that care homes are expected to uphold. Disciplinary procedures were in place if any staff behaved outside their code of conduct and these procedures had been followed appropriately. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual. They included clear measures to reduce the risks and appropriate guidance for staff. For example, a risk assessment had been carried out for a person who was at risk of choking. Control measures that helped minimise the risk of choking for this person instructed staff how to help this person while they were eating and drinking. Another risk assessment outlined the risks of a person having seizures and contained clear guidance for staff to follow. Other risk assessments about people's activities, such as swimming, trips and falls were carried out and included guidance for staff about how to manage the risks safely. Staff followed the relevant guidance that was provided in the risk assessments and the control measures were followed in practice to keep people safe.

Accidents and incidents were recorded and monitored daily by the registered manager. They were reported and discussed at monthly service management meetings attended by the providers and managers. Action was taken to reduce the risks of recurrence. For example when a person had displayed signs of increased anxiety, this had been reported to their local authority case manager, a professional meeting had been held, and their care plans had been reviewed to ensure any hazards that had been identified were reduced. The registered manager told us, "Such occurrences are also discussed at handovers and at each review of the person's care." The Operations and Compliance Director visited every month and discussed with the registered manager any concerns they might have about people. This system ensured that incidents and accidents were monitored so that action was taken to minimise future risks and keep people safe.

Fire drills and evacuation drills were practised quarterly and all fire protection equipment was checked weekly. This included a fire alarm, fire doors, fire extinguishers, heat, smoke and fire detectors and emergency lights throughout the premises. The fire protection equipment was regularly serviced and maintained. The last service was carried out in May 2015. Window restrictors were in place to ensure people's safety. All staff were trained in first aid and fire awareness. First aid kits were checked regularly and replenished when necessary. People had personal evacuation plans and individual risk assessments about possible emergencies. Staff were aware of their location and were knowledgeable about each person's needs in case of emergencies.

The premises were kept secure. People had their own room keys and they could safely use these to feel safe in their room and to protect their belongings. The registered manager, deputy manager and senior care workers operated an out of hours call system which meant emergencies could be responded to promptly. This system also ensured that people were able to access advice or guidance without delay.

The provider had an appropriate business contingency plan specific to the service that addressed possible emergencies such as extreme weather, infectious disease, damage to the premises, loss of utilities and computerised data.

Good

Is the service effective?

Our findings

Staff provided support effectively to people and followed specific instructions in their care plans to meet their individual needs. People knew each member of staff by name. One person told us, "[My key worker] is my friend, she helps a lot" A key worker is a named member of staff with special responsibilities for making sure that a person has what they need. Another person said, "Staff help me." Two relatives told us, "The staff are very efficient, they are always on the case and get things done without any problems" and, "The staff are on the go and give 110% all the way."

Staff had appropriate training and experience to support people with their individual needs. Staff confirmed they had received a comprehensive induction over 12 weeks and had demonstrated their competence before they had been allowed to work on their own. There was an effective 'finger print recognition system' in place to ensure waking staff remained awake and vigilant during night time. Staff checked into this system every half hour to evidence they remained awake and alert.

Records showed that all essential training was provided annually and was current. This included training in the principles of the Mental Capacity Act 2005 (MCA), infection control, manual handling, food hygiene and the safeguarding of adults. Staff had the opportunity to receive further training specific to the needs of the people they supported. This included training about epilepsy awareness, autism and behaviours that challenge. Staff told us that due to their training they felt confident to deliver the support people needed. One member of staff told us, "We are well trained and prepared for any eventualities." We observed staff putting their training into practice by the way they supported people and communicated with them.

Staff were supported to gain qualifications in health and social care while working in the service and had gained diplomas in health and social care at levels two and three. All members of care staff received monthly one to one supervision sessions to support them in their role. One member of staff said, "We get full support". All staff were scheduled for an annual appraisal to evaluate and discuss their performance. This ensured that staff were supported to carry out their roles effectively.

We discussed the requirements of the MCA with the registered manager. They demonstrated a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. All staff were trained in the principles of the MCA and were knowledgeable about the requirements of the legislation. People's mental capacity had been assessed appropriately, for example about being vaccinated, accepting their medicines, managing their finances or selecting and making significant purchases. When people had been assessed as not having relevant mental capacity, meetings were held in their best interest to decide the way forward using the least restrictive option. Independent mental capacity advocates had been called to attend these meetings to represent people's views when appropriate. A local authority case manager who oversaw a person's care in the service told us, "The staff were exemplary when they had to deal with a particular complex situation; they were very sensitive to the person's physical and psychological needs."

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Appropriate applications for DoLS had been submitted for people who were unable to come and go as they pleased unaccompanied.

Our observations confirmed that staff sought and obtained people's consent before they helped them. People's refusals were recorded and respected. Staff checked with people whether they had changed their mind and respected their wishes. A person had changed their mind about attending an activity and the staff had re-arranged their plans to accommodate this wish. A member of staff told us, "People change their mind all the time, often in split seconds and we respect this, they are in charge." This meant that people were in control of their care and treatment.

We observed food being prepared and provided. People told us they liked the meals. They said, "My favourite food is chips and fish fingers" and "I like it [the food]" People who needed support with eating were helped by staff who prompted and encouraged them. People who were able to prepare food for themselves were encouraged to do so with

Good

Is the service effective?

discreet supervision. Food was served in appropriate portions, was hot and appeared well presented. A member of staff told us, "The evening meals are cooked from scratch and people occasionally help; we encourage people to prepare their own lunches such as sandwiches, soup and buttered toasts and yoghurts for example." Staff ate with people and promoted the eating of fresh fruit and vegetables. A relative told us, "The staff are aware of what my family member should and should not eat." Individual dietary requirements were displayed in the kitchen and staff ensured people selected appropriate food to maintain their health. Cold and hot drinks were available throughout the day and upon request. This meant that people's nutritional needs were met effectively.

People's needs were assessed, recorded and communicated to staff effectively. There were three daily handovers and a staff communication book to ensure information about people's support was communicated effectively between shifts. We observed a handover taking place where people's individual needs were discussed. This system ensured that updates about individual needs were effectively communicated and discussed to ensure continuity of care and support.

All the staff we spoke with were knowledgeable of the specific needs of people and communicated well with them. They told us, "During the induction, each member of staff must spend a week with each client to get to know them personally and know how best communicate with them." People's care plans included 'Ways I communicate my feelings' and 'Important information about how I communicate with others and how you should communicate with me'. One person used the internet to contact their relatives and was helped by staff. Staff were aware of the guidance in people's communication care plans and were able to read body language and facial expressions to identify people's mood and wellbeing.

Specific communication methods were used by staff. For example, a person used a picture exchange communication system (PECS). Staff were updating a pictorial board with pictures of tasks or activities, and as the tasks were completed, people were encouraged to remove the pictures to a dedicated place. This was recorded in their communication care plan. Another person used their own sign language and staff had learned this language to communicate with them effectively. A member of staff told us, "Communication is the key to establishing a good relationship with the residents, if we cannot understand them we set them to fail." A person was given five minutes warning before they prepared for an activity. Staff told us, "Ten minutes is simply too much for this person as they would become anxious, we are all aware this notice system works for this person." People had 'communication passports' when needed, for example if they needed to go to a hospital for treatment. These passports contained information to explain the most effective methods to communicate with people. This meant people's voice could be heard effectively.

People were involved in the regular monitoring of their health. People were reminded by staff about appointments with health care professionals and were accompanied. When staff had concerns about people's health this was reported to the registered manager, documented and acted upon without delay. People were weighed monthly and food and fluid intake charts were kept and monitored for people whose appetite had declined. Referrals to a dietician, a neurologist and a speech and language therapist had been made appropriately when concerns were raised about people's health. Two G.Ps visited upon request and a senior practice nurse from the local GP surgery carried out routine health checks. People had a review of their health and medical needs every six months. A chiropodist visited the service every six weeks and an optician visited some of the people upon request. Dental check-ups were scheduled and followed up. One person who was at risk of chest infections had received a vaccination against influenza. Outcomes following visits from healthcare professionals were recorded and discussed amongst staff who were aware of changes in people's health. This ensured the delivery of people's care and support responded to their health needs and wishes.

Good

Is the service caring?

Our findings

All the people we spoke with told us they were satisfied with the way staff supported them. When asked whether staff were kind, they replied, "Yes", "I'm happy here", "Lovely". Relatives told us staff were "Wonderful, very kind, very friendly", "Incredible; there is not a high enough pedestal for them" and, "There is such a family feel about this place, the staff make it home". A relative told us how they thought their family member was "Well treated, kept occupied, in a routine he can understand; getting him to live in this home is the best thing we could have done for him."

Positive caring relationships were developed with people. We observed staff interacting with people with kindness, respect and sensitivity. Staff told us they valued the people and spent time talking with them while they provided support. One member of staff said, "The residents are like members of our family in a way, they are all individuals and we value them as such." A relative told us, "The staff go beyond their duties many times." For example, a key worker had chosen to accompany a person to hospital out of their shift hours to ensure they were reassured by their presence while in unfamiliar surroundings.

Staff were made aware of people's likes and dislikes to ensure the support they provided was informed by people's preferences. People's files included information about what people enjoyed and what they used to enjoy in the past. People were referred to respectfully in their care plan. A section was dedicated to 'What people like and admire about me'. This information was provided by people or their relatives. Staff consulted these files and were aware of people's individual likes and dislikes. They respected these in practice. For example, staff knew about one person's historical dislike of escalators, and this was taken into account during outings. A person enjoyed helping with housework and staff encouraged the person saying, "Come on, let's do some team work!" They knew about a person's specific anxiety when they anticipated receiving visitors. Staff took care of forewarning the person just enough time in advance to minimise this anxiety.

Clear information was provided to people about the service, in a format that was suitable for people's needs. This included information about how to complain, 'Abuse and what to do about it', support plans, outings, menus, timetable and activities. Menus and individual timetables were displayed. The provider had an updated website about the service that was informative and easy to use. A monthly newsletter was regularly sent to people's relatives and local authorities case managers. Staff photographs and their titles were displayed so that people and visitors knew who was on duty at any particular time and who they communicated with. All the people we spoke with were able to name their key worker and each member of staff with confidence. We observed how staff explained and presented several options to a person about the activity they had chosen for that day. This meant that people were appropriately informed by staff.

People were involved in the initial planning of their support before they used the service. They actively participated in the monthly and annual reviews of their support plan which were also updated whenever they wished. For example, when they chose to start a new activity or had changed their mind about the support they wished to have. Relatives were invited to take part in the reviews when people consented to this. This involvement ensured that the support provided remained appropriate to people's needs and requirements.

The service had information about advocacy services that they could share with people and followed guidance that was provided by the local authority. An independent mental health advocate had been used appropriately during a meeting where risks and a person's best interest had been discussed. An advocate can help people express their views when no one else is available to assist them. A local authority case manager who oversaw several people's care in the service told us, "This service is mindful of people's views and make sure these are represented accurately."

People's privacy was respected and people were supported in a way that respected their dignity. The staff had received training in respecting people's privacy, dignity and confidentiality. Staff were mindful of people's rights to privacy, knocked on bedroom doors and waited for people's authorisation to come in. One member of staff told us, "Sometimes they need some time out and want to relax in their bedrooms and we respect that."

The service held updated policies on confidentiality, privacy and dignity, mobile phones and the use of social media. Staff were made aware of these policies and of any updates.

Good

Is the service caring?

People were at the heart of the service and their independence was actively promoted. A person who was absent on the day of our inspection had chosen to prepare a hand-held video film that showed them living in their environment and interacting with staff. A member of staff told us this had been their idea and how this had been facilitated. The person appeared very proud to show his home and also spoke on the film about the building works taking place which showed how people were kept informed about their surroundings.

Support plans and observations showed that staff encouraged people to do as much as possible for themselves. For example, some people processed their laundry, prepared their breakfast and meals, vacuum-cleaned areas, tidied up their bedrooms and ironed their clothes. When help was needed with completing a task, staff supervised and helped in a discreet manner and handed control back to people as soon as possible. One person had learned how to use cutlery safely and had been assessed as being independent in the kitchen. People participated in the planning of groceries shopping. People had access to the internet if they wished and had full access to a phone landline to remain in contact with people who were important to them. People followed a wide range of activities programme of their choosing. This meant that people's independence was actively promoted in the way care was delivered.

People's wishes regarding resuscitation and end of life care were discussed sensitively when this was appropriate and were recorded.

Good

Is the service responsive?

Our findings

People received support that was responsive to their individual needs. People described some of the activities they took part in and appeared enthusiastic. They told us, "I do Maths Tuesday morning", "I love going to Pontins, my favourite", and, "I like when we go to the sea." A relative told us, "The residents are kept occupied and stimulated, they always have something to do that they like or choose to do."

The registered manager carried out people's needs and risk assessments before they came to live in the service. This included needs relevant to their health, communication, likes and dislikes and social activities. The staff were made aware of these assessments at team meetings to ensure they were knowledgeable about people's particular needs before they provided care and support. These assessments were developed into individualised care plans with people's participation. Two people had been assessed to live in the service when the building works finished. A period of transition was planned to help them acclimatise themselves to new surroundings. The registered manager told us, "New people are encouraged to come for an hour or more to start with, attend a barbeque or an evening meal, or stay overnight, participate in an activity, their transition period will take as long as they need."

People's care was planned taking account of what was important to them, including goals of their choosing. People had an 'Essential life plan' that was centred on their specific wishes. One person's goal was to re-design the interior decorating of their bedroom. Staff helped the person manage a saving plan towards that goal and helped her select paint, stencils and bedding. One person's goal was to return to Disneyland for a vacation, another person to attend a college course in English and another person to attend a night club twice a week. These goals had been attained and the identification of further goals was encouraged to keep people focussed on their achievements.

Care plans were developed with people's full involvement and included their specific requests about how they wished to have their care and support provided. The care plans included clear details of the help people required with their physical, medical and psychological needs. For example, 'What I need to stay healthy and safe; my likes and dislikes; what is important to me, how I communicate with others."

People's individual interests and preferences were recorded, such as when they liked a music band, a television series, or preferred a particular colour theme in their environment. Staff were aware of people's preferences. A member of staff told us how a group of people enjoyed attending church in the village for singing and meeting people in the community, and how a person disliked crowded environments. This was recorded in their care plans. A person preferred to run their own bath and their care plan included instructions for staff to supervise this task, check the water temperature and that a non-slip mat was in place.

People's individual assessments and care plans were reviewed routinely to ensure they remained appropriate in meeting people's individual needs. People or their legal representatives were involved with these reviews and were informed in advance when the reviews were scheduled. This ensured people were able to think in advance about any changes they may wish to implement.

People's care was updated following reviews or when changes occurred in their needs. For example, a person's support plan and risk assessment had been reviewed and updated following an increase of their anxiety levels while using transport. Updates concerning people's welfare were appropriately and promptly communicated to staff at staff handovers, at team meetings and using a staff communication book. A case manager who oversaw a person's care told us, "The service is good at keeping us informed about any changes in needs." This showed that people's care plans were updated and people's needs were met in practice responding to their changing needs.

People followed an activities programme that was extensive and tailored to their individual requirements. There was a shed in the garden which had been converted in a sensory room with appropriate equipment. Staff told us people enjoyed spending quiet times in the sensory room when accompanied by staff. People attended a day centre at individual times of their choosing and were able to change their mind about activities. A person had wished to go to the local tip and this had been facilitated. People's hobbies and interests were accommodated and people went out to air shows, day centres, horse riding, bowling, swimming and trampolining. Photographs of people on day trips to London, a neighbouring village, and Christmas Fayres showed how people enjoyed these outings. Staff told us how people enjoyed attending a night club that

Good

Is the service responsive?

provided fancy dress or 'doughnuts' nights and a snow machine. People participated in outings to the circus, theme parks, and garden parties. A barbeque was planned where people who lived in another local service were invited. This ensured that people maintained links with their community and were socially included.

Annual holidays were discussed at resident meetings and people's individual choices were respected and accommodated. For example, one person came back from a three day break to the seaside and they had been accompanied by two staff. Another person had gone to Disneyland accompanied by one member of staff. The provider made resources available to ensure each person had a yearly holiday and to finance suitable activities for all.

People's views were sought and acted upon. For example when people saw a particular type of pancakes on television, they told staff, "We want that" and this was now a regular item on the menus. Staff enquired about people's satisfaction about their care and support at each review of their support plan. People attended monthly residents meetings where they discussed and shared their views freely about any aspect of the service. They also met with their key worker every month to discuss their level of satisfaction. Records indicated people were satisfied about the staff and their care and treatment. Additional annual questionnaires were provided to people's relatives. A survey was sent at the time of our inspection and had not yet been completed. The last annual survey indicated a high level of satisfaction. Comments that had been provided were very positive and included, "Great key worker, our family member does a wide range of things he enjoys", "[X] made remarkable progress" and, "Excellent care all round." A survey for gathering healthcare professionals' feedback was scheduled to take place in July 2015.

Staff were consulted at regular team meetings and were encouraged to suggest improvements about any aspect of the service. Records of team meetings indicated that staff's voice was listened to. Staff had recommended new activities people might enjoy and resources had been made available to implement these suggestions. Staff had proposed a shed to be converted as a sensory room and this had been acted on. Staff told us, "We feel valued, we don't need a comments box, we talk and we get heard."

The provider had a complaints policy and procedure that had been updated in March 2015. One complaint had been lodged with the service since our last inspection and had been resolved promptly and satisfactorily.

Good

Is the service well-led?

Our findings

Our discussions with people, their relatives, the registered manager and staff showed us that there was an open and positive culture that focussed on people. People we spoke with knew the registered manager and the staff by name. A person told us, "She's nice and works with me". Relatives told us, "The manager is wonderful, kind, she gets things done" , "The manager and deputy manager are totally approachable as are all the staff there; they are quick off the mark and very efficient about informing us and taking the steps that are needed for any health related matters."

Staff told us they positively appreciated the registered manager's style of leadership. One member of staff told us they had been inspired by the registered manager. They told us, "I would not do what I am doing now if it was not for her" and, "She works on the floor three times a month so she knows what is going on and can see delivery of care from our perspective". Another member of staff told us how their rotas had been accommodated to consider their childcare duties. They said, "She is brilliant, supportive and understanding." A local authority case manager who oversaw people's care in the service told us, "This is a well organised service that genuinely cares for people."

There was an 'open door' policy where people and members of staff were welcome to come into the office to speak with the registered manager at any time and we saw that they did this several times during the day. Members of staff confirmed that they had confidence in the management. They told us, "We know that if we voice any concerns we are listened to." Staff were encouraged to make suggestions about how to improve the service and these were acted on. The registered manager told us how they valued staff and expressed their appreciation, for example at team meetings or with the provision of gift vouchers when staff 'went the extra mile'. Competency checks and observations of staff at work ensured good standards of practice were maintained. The registered manager told us, "We have a great team of dedicated workers who work well together."

Staff had easy access to the provider's policies and procedures that had been reviewed and updated on an on-going basis by the Operations and Compliance Director. The Director told us, "We have created bespoke policies which are easy to understand and easy to use." We selected a sample of policies that had been updated appropriately. They had been written in an easy to read and understand format. A member of staff told us, "The policies are easy to follow and very clear about we have to do." There were policies that were specific to the service, such as policies on 'Accountability and the Boundaries of Staff Client Relationships', 'Risk taking' and 'Self-awareness and sexuality'. All staff had been informed when updates had taken place and signed to confirm they were aware of the updates. This ensured that the staff were aware of procedures to follow and of the standards of work expected of them to provide safe, effective, responsive care and support for people.

Residents meetings, team meetings, and house meetings were organised regularly and recorded.

Staff were reminded at team meetings to report any health and safety issues to the registered manager or deputy manager. They recorded any needs for maintenance in a repairs book and this was monitored by the registered manager.

The registered manager carried out monthly audits that included medicines, documentation, health and safety, premises safety, staff training and fingerprints scanner checks. These identified any issues and remedial action was scheduled and monitored until completion. A health and safety audit had identified a need for an adjustment of water temperature and this had been rectified by a person responsible for the maintenance of the premises. A staff training audit had identified a need for further scheduling of epilepsy awareness training and this had been implemented as a result. These audits were communicated monthly to the Operations and Compliance Director who ensured a further system of quality assurance checks was implemented. The director carried out quarterly audits to check compliance with the Regulations 2014 of the Health and Social Care Act 2008 and additional 'themed audits' every three weeks. These audits focused on specific areas such as medicines, mental capacity, documentation, surveys and health and safety.

When shortfalls were identified as a result of these audit checks, lessons had been learned and the registered manager had implemented changes in the service. When an audit of accidents and incidents had highlighted a need for some bedrooms layout to be changed, this had been acted on to minimise further risks for people. An audits on the administration of medicines showed a mistake had occurred and the registered manager had taken

Good

Is the service well-led?

disciplinary action. The provider had ensured new equipment was purchased to keep people safe. For example, double beds had been purchased for people with nocturnal seizures. Recent purchases had been carried out to replace furniture, kitchen appliances and a boiler.

The registered manager notified the Care Quality Commission of any significant events that affected people or the service. Records indicated the registered manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

The registered manager met with other managers from sister homes every six months to share ideas and attain or provide support. There was a system of email communications that ensured regular contact between these managers was maintained to discuss any issues relevant to the management of their services. The registered manager consulted websites such as the Social Care Institute for Excellence and the Epilepsy Society to keep updated about current research.

We asked the registered manager about their philosophy of care. They told us, "Although we are labelled as a care home, this is our clients' home. We listen to everything they have to say and we get involved in every single thing which is important to them where we can make a positive difference. Gresham House gives that little extra: we listen and advocate for people who cannot speak and make sure their voice is heard."

People's records and staff records were kept securely. Archived records were labelled, dated and stored in a dedicated space. They were kept for the length of time according to requirements and were disposed of safely. All computerised data was password protected to ensure only authorised staff could access these records. The computerised data was backed-up by external systems to ensure vital information about people could be retrieved promptly.