Prospects Supported Living Limited

Stonehaven

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?	Requires Improvement

Summary of findings

Overall summary

We carried out an inspection of Stonehaven on 31 August and 1, 5 and 6 September 2016. The first day was unannounced.

Stonehaven provides accommodation for up to 5 people with mental health needs. The aim of the service is to provide people with care and support through a recovery and rehabilitation programme. The service is based in a residential setting within walking distance of local amenities. Accommodation is provided in single bedrooms. At the time of our inspection there were 2 people living in the home.

This was the first inspection of this service.

The registration requirements for the provider stated the home should have a registered manager in place. There was no registered manager in post on the day of our inspection. The previous registered manager had made an application to voluntarily cancel their registration and this was completed on the 17 June 2016. 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. A manager had been appointed and was currently processing their application to apply for registration.

People living in the home said they felt safe with the staff who supported them. Staff were described as being very supportive and non-judgemental. There were enough staff on duty and deployed in the home to meet people's care and support needs.

Safeguarding adults' procedures were good and staff understood how to safeguard the people they supported. There was a whistle-blowing procedure available and staff said they would use it if they needed to.

People's medicines were managed appropriately and people received their medicines as prescribed by health care professionals. People were supported to manage their medicines safely.

Risk assessments were in place to keep people safe and these were kept under review. Staff had a good understanding of risk management. People were encouraged to live their lives the way they chose and were supported to recognise this should be done in a safe way.

We found the premises to be clean and hygienic and well maintained. Regular health and safety checks were carried out.

Staff had completed an induction when they started work. Further training was planned to address specific topics. This included, drug and alcohol and the recovery star model used to support people in their pathway

to recovery.

The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation.

People were encouraged to take control in meeting their nutritional needs. They were involved in menu planning, food preparation and cooking as part of their rehabilitation.

We found staff were respectful to people, attentive to their needs and treated people with kindness and respect in their day to day care. Care plans were written with sensitivity to reflect and to ensure basic rights such as dignity, privacy, choice, and rights were considered at all times. Staff were knowledgeable about people's individual needs, backgrounds and personalities

People told us they had their privacy respected by all staff and they felt 'valued'. Each person had an individual care plan that was sufficiently detailed to ensure they were at the centre of their care. These were kept under review.

Confidentiality was a key feature in staff contractual arrangements. This helped to make sure information shared about people was on a need to know basis.

People told us about the type of activities they took part in with staff support. Staff helped people to acquire new skills that would prepare them for independent living and give them confidence.

People were given the opportunity to participate in individual therapy sessions to help them with their rehabilitation and recovery. People were given additional support when they required this. Referrals had been made to the relevant health and social care professionals for advice and support when people's needs had changed.

People told us they were confident to raise any issue of concern with the manager and staff and that issues they raised would be taken seriously. They had also been encouraged to express their views and opinions of the service through regular meetings, care reviews, and during day to day discussions with staff and management.

People said the management of the service was very good. There were opportunities for people to give formal feedback about the service, the staff and their environment in quality assurance surveys. Recent surveys showed overall good levels of satisfaction with the service provided.

There were systems in place to monitor the quality of the service to ensure people received a good service that supported their health, welfare and safety. We found regular quality audits and checks were completed to ensure any improvements needed within the service were recognised and appropriate action taken.

We recommended policies and procedures were updated to include first aid that had a mental health focus and an admission policy to support future admissions to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe. They were cared for by staff that had been carefully recruited and were found to be of good character.

People's medicines were managed in accordance with safe procedures and staff who administered medicines had received appropriate training

Staff were aware of their duty and responsibility to protect people from abuse and were aware of the procedure to follow if they suspected any abusive or neglectful practice.

Risks to the health, safety and wellbeing of people who used the service were assessed and planned for with guidance in place for staff in how to support people in a safe manner.

Is the service effective?

Good

The service was effective.

People were supported by staff that were trained and supervised in their work. Staff and management had an understanding of best interest decisions and the Mental Capacity Act 2005 legislation.

People's health and wellbeing was consistently monitored and they were supported to access healthcare services when necessary.

People were supported to have sufficient to eat and drink and maintain a balanced diet.

Is the service caring?

Good

The service was caring.

Staff were very respectful to people, attentive to their needs and treated them with kindness in their day to day care.

People were able to make choices and were involved in

decisions about their care. Staff had a good understanding of people's personal values and needs and placed people at the heart of the service they provided.

Is the service responsive?

Good

The service was responsive.

Staff were very knowledgeable about people's needs and preferences and supported people to live their life to the full. People's care plans were centred on their wishes and needs and kept under review.

People had the opportunity to participate in a range of appropriate activities to enhance their well-being.

People felt able to raise concerns and had confidence in the manager to address their concerns appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a manager in post who had not been registered with the Commission.

People made positive comments about the management and leadership arrangements at the service.

Systems were in place to assess and monitor the quality of the service and to seek people's views and opinions about the running of the home.

Policies and procedures were in place and we recommended these were reviewed to include first aid and best practice around admissions to the service.

Stonehaven

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 31 August and 1, 5, and 6 September 2016. The first day was unannounced.

The inspection was carried out by two adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local health and social care authorities contracting team for feedback and checked the information we held about the service and the provider. This included statutory notifications sent to us by the manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also received feedback from one mental health care professional. We used all this information to decide which areas to focus on during our inspection.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with the manager, deputy manager, three members of staff, two people living in the home and a visiting health care professional. We made observations on how staff and people using the service interacted with each other and we looked around the premises.

We looked at a sample of records including four people's care plans and other associated documentation, one staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, complaints records, medicines records, maintenance certificates and development plans, policies and procedures, completed audits and quality assurance surveys.

Good

Is the service safe?

Our findings

We asked people using the service what their view on being 'safe' meant to them. The comments we received included, , "Having the right staff", "Staff watching out for me" and "Feeling comfortable" in their home. One person told us "I trust the staff. If I'm feeling down they are always there for me. They don't judge me and I think they are great."

We looked at the recruitment records of one new member of staff. We found a number of checks had been completed before they began working for the service. These included the receipt of a full employment history, an identification check and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We spoke with the staff member who told us they had to wait for checks being carried out before they started work. They also told us they had two weeks shadowing senior staff before they were counted as part of the staff team on duty.

People using the service told us there were sufficient staff available to keep them safe and to help them when they needed support. The home had a rota which indicated which staff were on duty during the day and night. We noted this was updated and changed in response to staff absence. The manager told us they were currently recruiting extra staff. Planned leave was covered by existing staff and agency staff were not used. This ensured people were looked after by staff who were familiar with their needs. The skill mix of staff had also been considered and on all shifts senior staff were identified. There were on call management arrangements in place for out of normal office hours. Staff spoken with confirmed they had sufficient time to support people according to their needs and lifestyle.

Staff told us they had received safeguarding vulnerable adults training. This was also evident in induction programmes which staff undertook on commencing their role. Details included the procedure for staff to follow. in the event of an alert. Staff were fully aware of the service's safeguarding procedures and their responsibility in ensuring any concerns were reported immediately. They told us they were actively encouraged to raise any concerns they had regarding people's health, welfare and safety as part of day to day practice. One staff member told us, "I wouldn't hesitate to report any abuse to the manager. I'd take it higher if I needed it to, I wouldn't ignore it." Staff were also aware of the service's whistleblowing policy. They were confident the registered provider would deal appropriately with any concerns they raised.

We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. We saw that people's current medicines were confirmed on admission to the home. Medication was delivered pre packed which meant people's medicines had been dispensed into a monitored dosage system (MDS) by the pharmacist and then checked into the home by staff on duty. Corresponding Medication Administration Records (MAR) charts were provided and all the MAR's we checked were complete and up to date.

There were arrangements in place to make sure people had their medicines when on home leave. These were delivered by the supplying pharmacy in a monitored dosage pack. Medicines were signed in and out of

the home. This reduced the risk of people having access to more medicines than were needed.

Medicines were stored securely which helped to minimise the risk of mishandling and misuse. Medicines were checked at regular intervals to make sure they were being administered correctly. Appropriate arrangements were in place for the management of controlled drugs should these be prescribed. These are medicines which may be at risk of misuse.

Staff monitored medicines people had purchased that could cause harm if taken in excess. Staff maintained a record of these medicines handed in to them and when they were returned to the chemist for disposal. Training records showed staff responsible for medicines had been trained and their practice observed. Regular internal and external audits of medicine management were being carried out. This helped to reduce the risk of any errors going unnoticed and enabled staff to take the necessary action.

People could manage their own medicines following a risk assessment to ensure this was safe. This was part of a rehabilitation programme to enable people to manage their own medicines in a safe way. We saw evidence this was strictly audited and there was no time limit set for achieving a satisfactory conclusion.

We found support was planned and delivered to help protect people from avoidable harm. Each person's support plan included individual risk assessments. There were risk assessments in relation to supporting people who self-harm. Staff were aware of situations that could pose a risk to people and of potential triggers and indicators of relapse in people's mental health wellbeing. Information recorded was detailed and staff following this guidance would be able to identify if people were becoming anxious or unwell. Staff spoken with gave good accounts of their understanding of people's needs during this time and how this was being managed. One member of staff told us "I think risk management has really improved. Seniors on call are very supportive as well, and will come if needed. This gives you confidence when you are supporting people through difficult times."

People using the service described how staff helped them during critical times. One person told us "I can always rely on the staff here. They support me all the time." We found recorded evidence of instances to demonstrate staff had acted in line with guidance and followed the correct procedures in supporting people. Following any serious incident that impacted on people's health and welfare, a review took place. This helped to identify any learning points and to establish if any changes to practice were required. For example following an incident, knives and other implements that could be used to self-harm with were kept secure in a locked 'sharps' cupboard. Incidents were reviewed at the MDT (Multi-disciplinary Team) meetings.

Training records showed us staff had also received additional training on how to keep people safe which included fire safety and first aid. However, the first aid policy and the dealing with accidents and emergencies procedure made no reference to the effects of self-harming and how these should be dealt with in the home. The first aid policy dated 9 February 2016 stated 'All service users have person centred plans for specific self-harming incidents, these are to be followed as per plan.' We checked care plans and saw information on managing self-harming recorded for staff reference. The manager told us the first aid policy and harm minimisation/reduction policy were being reviewed and would include dealing with the effects of self-harming.

Part of a strategy of keeping people safe in the home was to observe their whereabouts and behaviour, particularly when an assessment indicated 'red' which equated to life threatening risk. We observed staff were present at all times with people, however there was no supporting paperwork to demonstrate this. The manager introduced an observation tool for staff to use during the inspection, and we were shown one that

was being completed.

We found that there was a rolling programme of training which included general topics such as fire training, infection control and medication awareness. A planned training programme was in place which showed further training on these topics was planned for. In addition to this training was provided in various topics such as risk assessment, eating disorder, personality disorder and self-harm. A written assessment was completed following training on ligatures to check staffs' understanding of ligaturing and associated dangers and to check their understanding of how to support and de-escalate someone who is engaging in this aspect of self-harm.

Environment risk assessments had been completed to identify any potential hazards, including possible ligature points. An external contractor had carried out a Health and Safety audit. We saw that reasonable action had been taken to address identified hazards that included, fixing anti ligature handles on doors and adaptations to domestic style bedroom furniture. We discussed other potential ligature points and hazards we could see such as shower fitments and cable wires that were not encased against the wall. The manager told us work was being carried out on the environment as part of ongoing maintenance. This included modifications of the environment to reduce any potential risk.

A health and safety representative had been appointed for the service. Environmental risk assessments also included regular health and safety checks such as water temperature monitoring, legionella testing and cleaning of showerheads, and the control of hazardous substances. We saw safety certificates to demonstrate equipment and electrical appliances and installations were serviced at regular intervals. Heating, lighting and fire equipment had been serviced and certified as safe and a list of trusted contractors was available for staff to refer to for contact in an emergency. The provider had arrangements in place for on-going maintenance and repairs to the building. Emergency evacuation plans were in place including a personal emergency evacuation plan (PEEP) for each person living in the home. We noted one person's failure to follow evacuation procedures was risk managed.

We found the service to be clean in all areas we looked at. We noted staff hand washing facilities, such as liquid soap and paper towels were available. Appropriate protective clothing, such as gloves were used. People using the service were given advice on wound management and provided with sterile dressings to help prevent infections. First aid boxes were routinely checked and supplies replenished when needed.

All bedrooms had safety locks fitted as standard on bedroom doors and people held their own key. The type of lock used enabled staff to override the lock with a master key and gain access when responding to an emergency. Security to the premises was good and visitors were required to sign when entering and leaving the premises.

Good

Is the service effective?

Our findings

People told us they had confidence in the staff who supported them. Their comments included, "Most of the staff know what they are doing" and "I feel like they understand me very well and give sound advice. I get the support I need and when I need it."

We looked at how the service trained and supported their staff. Information in the PIR told us the provider intended to develop staff training by moving away from on line training and to introduce skills for care. Most of the staff held a qualification in social care and the manager told us training was currently being developed to include outside agency input. We saw staff training certificates, and the overall staff training plan for the service. We were also given copies of all the staff team training records. These showed staff had received essential mandatory training and other training that included topics such as borderline personality disorder, self-harm, eating disorder, mental health awareness, ligature training, respect, risk assessment and management and equality and diversity.

We discussed training with staff. They told us they were given training to help to increase their knowledge and awareness and could ask for additional training if they felt they needed it. The training was relevant to their role and their focus was to meet the changing needs of people using the service. We could see from the training plan, the 'Recovery Star' model of care currently used at the service was scheduled for later in the month to be delivered by senior management. Staff we spoke with told us they had received an overview of this methodology and one member of staff told us they had been trained by an external trainer.

Some staff had completed training in other topics relevant to the needs of people using the service such as diabetes. We noted however most staff had not had training in drug and alcohol misuse although this was relevant to the support offered to people. We discussed this with the manager who gave us a copy of the service training plan which included drug and alcohol training from another agency. This was scheduled to be provided in the near future and they were currently waiting for confirmation on this. We discussed the importance of making sure staff had good training to deal with presenting problems the service was registered to provide before people were admitted to the home. Without the right training staff may not always follow best practice when dealing with problems of this type. Staff we spoke with told us they learned how to manage these needs by getting to know people really well and we saw evidence people were referred for specialist help if needed.

There was an induction training programme for new staff to help make sure they had some understanding of their role in supporting people. We saw evidence to demonstrate staff newly recruited to the home were initially supernumerary to the rota and shadowed more experienced staff to enable them to learn and develop skills. Staff spoken with commented, "I think training is much better now. We are supported in our role and have better guidance to follow. I love this job. If we are unsure about anything we just contact [manager] and get the support we need." Staff told us they were supported by the registered provider and received regular supervision.

Records showed checks had also been completed on staff working practice. These checks helped to identify

any shortfalls in staff practice and support the manager to identify the need for any additional training and support required. All staff had received regular supervision that was structured well and topics covered were relevant.

Staff told us handover meetings were held at the change of every shift. A communication diary and daily diaries helped them keep up to date about people's changing needs and the support they needed. Records showed information was shared between staff. One member of staff said, "We have a good team; we all work well together. Our work is flexible to accommodate individual needs and choices." Comments in a recent staff survey included "I have received relevant training in order to carry out my role effectively" and "Since coming into the company a short time ago I feel really supported within my role."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.

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.

All the staff team had received training in the principles associated with the MCA 2005 and the DoLS. We found staff had an understanding of the relevant requirements of the MCA and understood the importance of gaining consent from people and the principles of 'best interest' decisions. Policies and procedures in relation to the MCA and human rights were available for staff reference.

The manager told us people currently using the service were not subject to compulsory measures under the Act. The service used a mental health recovery star approach to support people to manage their mental health care needs that involved decision making. The mental health recovery star is underpinned by a five stage model of change leading to self-reliance. Staff we spoke with explained their work around the decision making process and what measures they took when people were clearly unwell and needed further treatment. Care records we looked at showed people's capacity to make decisions for themselves had been assessed before they stayed at the home. Care records demonstrated people's capacity to make decisions for themselves in all aspects of their lives was kept under review.

We saw that the manager and staff co-ordinated their support for people with health and social care agencies involved in people's continuing health and social care. People were registered with a GP and had access to a range of healthcare services. We spoke with one healthcare professional visiting people using the service. We asked them to comment on how the service worked with them to support people in their care. They told us they liaised with staff and if there were any specific instructions they wanted staff to follow this was recorded. We noted a comment by a healthcare professional relayed to staff in a staff meeting in July 2016 praising them for the support for people living at Stonehaven.

People's health care needs had been assessed and people received additional support when needed. Their healthcare needs were considered within the care planning process and kept under review. This helped staff

to understand the extent of people's needs regarding their health and to recognise signs of deteriorating health. Records were maintained in relation to healthcare issues and people were supported if appropriate to attend appointments. During our visit one person was supported to attend an appointment for dental treatment and another person supported to attend a hospital appointment.

From our discussions and a review of records we found the staff had developed good links with other health care professionals and specialists to help make sure people received prompt, co-ordinated and effective care. We saw a hospital transfer record with all essential details about each person had been completed for all people. This was used in the event of an admission to hospital.

We looked at how people were protected from poor nutrition. We were told by staff people were encouraged to eat healthy food and to consider their dietary requirements. Staff we spoke with told us they had training in eating disorders. The manager told us each person had a budget of £40 allocated from the company to purchase foods of their choice. As part of their rehabilitation plan they were supported to plan menus, shop for food, prepare and cook meals and if they wanted did baking. Each person had appropriate storage facilities for the food they purchased that included a fridge and freezer. During the time we were in the home we observed one person cook some nutritious meals and deserts. This was appreciated by all who sampled it, in particular the banoffee pudding. All meals were made with fresh ingredients. One person told us, "I love cooking. We cook for each other, it's like that here. We get on really well. Staff always have time to help us if we need it. They join in anyway."

Good

Is the service caring?

Our findings

People we spoke with told us they were cared for very well by the staff. They commented, "Yes I do feel cared for and that I matter. Staff are genuine, kind and caring." "I've been in a lot of services before I came here. This is definitely the best." People also spoke in terms of 'getting on' with staff and told us of ways staff showed them kindness, respected them and made them feel more confident in their lives. It was evident from talking to people using the service and staff, people were valued and success and achievements were celebrated.

We found that staff were compassionate and caring when they talked about the people they cared for. One member of staff told us, "I think all the staff working here have the person's best interest at heart. We want people we support to achieve their goals and we are always there for them in their journey. They are remarkable the people we work with. Their journey in life has been difficult and life has not always been kind to them. They trust us and we do all we can to support them to move on and live an independent and meaningful life." Another staff member told us, "I really enjoy my job. It's good to see people get better and move on with their lives. We are like family here." The manager and staff we spoke with told us two people had moved successfully into the community with their support.

Staff spoke about people in a respectful, confidential and friendly way. During this inspection we observed how staff interacted and related to people using the service. They spoke with people about the positive things they had achieved and discussed their future plans. Communication was seen to be very good and daily records completed by staff were written with sensitivity and respect. All staff had been instructed on confidentiality of information and they were bound by contractual arrangements to respect this. People's records were kept safe and secure.

Staff spoke about the challenges people faced in achieving their goals and prejudices people faced in their lives. People were not excluded from community involvement and were supported to live as valued members within the home and wider community. We were impressed to hear how one staff had challenged discrimination within a community setting in support of a person using the service. This had resulted in the person having confidence to partake in an activity they wanted to do.

We spoke to one person regarding privacy issues and asked them what that meant for them and their friends living in the home. We were given good examples that demonstrated people's privacy was considered all the time. We were told, "We've got keys now for our bedroom doors. I can lock my room if I want. At the moment I don't feel I need to, we just don't go in other people's rooms. It hasn't always been like that." And "I trust the staff and feel I can tell them anything. I can always speak to staff in private if I want.

Staff we spoke with told us they worked alongside people as key workers using the mental health recovery star program, supporting them to develop their individual recovery-focused plan. The system helped them support people in a person centred way. For example one staff member told us, "It's good for relationship building with people. We've known some of these people for some time now and we understand their needs

very well. It takes time to build up a trusting relationship and it's important we maintain that trust." The manager told us people could choose who they wanted to support them.

The manager told us people could access advocacy services if they needed this support. This was something they would help them with. An advocacy service is provided by an advocate who is independent of social services and the NHS, and who isn't family or friend. They support people, especially those who are most vulnerable in society, to have their voice heard, access their rights and have more control over their lives.

People were encouraged to express their views during daily conversations, residents meetings and satisfaction surveys. At the last resident meeting in July 2016, the agenda was varied and people using the service contributed to the meeting. For example a suggestion was made for having a larger vehicle so that everyone could go out for short breaks together. At the meeting people had also been told of a new house rule that had been put in place across all the homes in the company with regard to closing communal areas at midnight. We asked people if they had been consulted about this. One person we spoke with told us, "It's new to us but it's not relevant here anyway, so it doesn't really affect us. If it did we would have something to say no doubt. We are quite happy with the changes."

Information was available about the service in the form of a service user guide. This provided an overview of the service and facilities. When people moved into the service they were given a copy of the service user guide that included all the information they needed to know about.

We looked around the premises and noted people who were currently in hospital had their possessions protected. Their rooms were locked and their belongings kept tidy. We were told people received their mail unopened and we noted in a residents meeting people had discussed having plastic boxes for their mail. This was being considered.

Good

Is the service responsive?

Our findings

We looked at how the service made sure that people received personalised care and support.. The manager described the service's referral and assessment process. This involved gathering information from the person and other relevant sources, including the person's care co-ordinator/social worker and psychiatrist.

The manager told us all admissions were planned. This included carrying out an assessment with the person and health and social care professionals. These assessments were essential in determining if the placement was suitable and if staff had the skills, knowledge and experience to support the person as they required. Once all parties had agreed to the placement, people spent time at the home on day visits and had overnight stays. This process allowed people to meet with other people using the service and with staff who would be providing their care and support. It also provided people with an opportunity to familiarise themselves with the location of the service and to consider if the support offered and terms and conditions of their stay met with their expectations.

We were shown good evidence of an admission that was currently being planned for. The process was proving very useful in preparing for the person's stay and ensuring staff could respond to their needs in a timely and personalised way. One staff member told us of an environmental adjustment they were making to provide the person with a way to discreetly summon staff help when needed. They were able to describe strategies they had put in place to accommodate and respond to the person's presenting needs and were fully aware of all relevant background information that would support them in managing the person's care.

We saw an example however where one person's transition into the service was not managed this way. Assessment notes showed the person was anxious and had a low self-esteem and low confidence. It was clear from emails we viewed the placement had been agreed with a care coordinator, the managing director of the service and the person involved. However, the person did not take the opportunity to spend much time at the service. This meant the person was cared for by staff they did not know, they were not familiar with the area and had not had time to build a relationship with other people using the service. Within a very short period of time there were three incidents of self-harm that required hospital treatment and two admissions to hospital.

We discussed the importance of a good planned admission with the manager that would ensure people's needs were met and people felt confident and happy with their decision to move into the home.

We looked at the processes followed in designing people's care and ensuring their needs were met within the balance of risks and benefits. We looked at three people's care plans and found these were comprehensive and reflected the complexity of their needs. This supported staff to understand each person's individual requirements, and take into account their personal, health and social circumstances.

Staff described how they delivered support in response to people's individual needs, abilities and preferences and told us of the progress some people had made in their recovery and rehabilitation programme. The methodology they used (Mental Health Recovery Star) enabled people using the service to

assess and identify their needs, choices and preferences and plan how they can build a satisfying and meaningful life. People completed these with the support of staff.

The care plans showed people were working through their mental health recovery star tool with the support of staff. This took into account their mental health needs, physical health and self-care living skills, social networks, work, relationships, addictive behaviour, responsibilities, self- esteem and trust and aspirations. We saw arrangements were in place to respond appropriately and in good time to people's presenting and complex needs and risks. There was evidence people had been supported to have strategies in place to manage periods they were unwell. These were kept under review. People also had the opportunity to participate in individual therapy sessions with their support workers and psychologist who visited the service every week.

Care records showed people were involved in discussions and decisions about meaningful activities, developing skills and accessing community resources. One person we spoke with told us of their accomplishments to date and of their hopes for their future. They were involved in discussions and decisions about the type of activities they might like to take part in. Staff planned for the week ahead with people to provide structure for daily living.

We saw people engaged in a wide range of activities. These included fund raising for charity, shopping, cooking, days out, meals out, swimming, care of pets and charity work. One person told us they were hoping to work in a soup kitchen and staff were supporting them with this. Staff we spoke with were enthusiastic in supporting people to engage in various activities. They understood the value of people leading meaningful lives. We were given examples of people whose lives had changed and who were successfully living independently in the community. The manager told us one person was planning to move to independent living and staff were supporting them and working closely with other professionals to support this.

The manager told us they were in dialogue with people on a daily basis and if any issue was to crop up this would be dealt with straight away. People told us they would feel confident talking to a member of staff or the manager if they had a concern or wished to raise a complaint. One person said, "I would definitely make a complaint if I felt I needed to." Staff we spoke with knew what action to take should someone in their care want to make a complaint and told us they wouldn't hesitate to raise this with the manager and spoke confidently any concern raised would be dealt with appropriately. There had been no complaints from people using the service.

Meetings were held every month with other agencies directly involved in people's care to discuss their progress. People had a transfer of service pen profile completed. This contained essential information other services would need to know, to help support people receive continuing care and to support their movement to another service.

Requires Improvement

Is the service well-led?

Our findings

We looked at the culture of the service and how it promoted person-centred support and involved people in how it was run. One person told us, "I'm happy here. I'm working with staff to move out and be independent. I think the staff are really good and very helpful. I can honestly say I trust all the staff to support me as I want them to. We plan our own lives and there are no restrictions placed on us. It isn't a case of 'can't do' but more 'can do'. [Manager] is quite new but she is really good. She always has time to talk to us and ask us how we are."

The registered manager had resigned from her post and had voluntarily cancelled their registration with the Commission in June 2016. There have been three different managers registered with CQC for this service since 2014. There was a manager in post at the time of our visit. They had taken up this position in April 2016 and they informed us they were in the process of submitting an application to be registered as manager with the Commission. They had worked alongside the previous registered manager to familiarise themselves with the operation of the service. A deputy manager was also appointed to support her in her work. The manager and deputy manager told us they were supported by the managing director of the company.

From our discussion with both manager and deputy manager it was clear they were able to demonstrate they had a very good working relationship and were seen throughout this inspection to take a proactive approach to improving the quality and safety of the service. They had a detailed understanding of person centred care and what this meant for people in their daily life. We could see for example, care plans promoted people's independence whilst at the same time balancing against safeguarding people from harm and enabling them to lead a more independent life. We were told the manager and deputy manager were currently working through all the care plans and making sure they were up to date and reflective of people's needs.

There was a clear management structure and staff were aware of the lines of accountability and who to contact in the event of any emergency or of any concerns they had. If the manager was not present, there was always a senior member of staff on duty with designated responsibilities and on call arrangements for support to deal with more complex issues.

Staff spoken with were very complementary about the management of the service. They told us the manager worked alongside them and was very approachable, a good listener and appreciative of their work. They had been provided with job descriptions, staff handbook, employment policies and procedures and contracts of employment which outlined their roles, responsibilities and duty of care. One staff member told us, "The service is well led. [Manager] is very good and will listen to what you have to say. I'm confident I can approach her for advice and support any time." Another staff member told us, "It's lovely working here. I personally think we are well supported and we work well as a team. We all want the best for people and it's rewarding when you see people moving on and know this happened with your support. We try our best to provide a good service."

The manager used various ways to monitor the quality of the service. We were shown quality auditing

systems or processes to assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others. This included audits of the medication systems, health and safety arrangements, incidents and accidents, staff training and staff supervisions, complaints and infection control. These checks were designed to ensure different aspects of the service were meeting the required standards. Management meetings were being held regularly and the minutes from the meeting held in August showed managers were reminded to formulate action plans following audits and to indicate when actions were completed.

We looked at the result of a quality monitoring survey completed by staff in May 2016. We saw some positive comments. One comment referred to "Training is given but not always as quickly as needed." We discussed this statement with the registered manager. From the training records we had been given we noted some essential training was not provided at the time a person with a history of alcohol misuse had been admitted. We were confident however this training was arranged together with further staff training in the use of the recovery star model they used. This should support a well trained staff team.

We discussed policies and procedures with the manager. A number of policies were available for staff reference such as accident and incident reporting (RIDDOR) policy, dealing with accidents and emergencies policy and a first aid policy. However these policies need to be enhanced to reflect a mental health care focus. The admission policy was not available to look at. We recommended these policies be reviewed to make sure they were robust and effective to ensure best practice was consistently followed.

It is recommended that the policies and procedures are revised so that they are mental health focused and are based on best practice guidance such as that produced by the National Institute for Health and Care Excellence (NICE).