Mr Anthony Delannoy and Mrs Hannah Delannoy

Sea Gables Residential Home

Inspection report

6 Northcliff Gardens
Shanklin
Isle of Wight
PO37 6ES

Tel: 01983861473

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Sea Gables Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This inspection took place on 1 and 3 October 2018 and was unannounced.

The service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Sea Gables is registered to provide accommodation and personal care for up to seven people and seven people were being accommodated at the time of the inspection. The home is based on two floors and is situated close to local facilities and shops. All bedrooms had en-suite bathrooms and there was a choice of communal areas where people could choose to spend their time.

The home had a registered manager. 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.

At our last inspection, in May 2016, we identified no concerns and rated the service as good. At this inspection, however, we identified some areas for improvement.

CQC were not always notified of significant events. There was a quality assurance process in place, but this was not always used effectively to identifying concerns and bring about improvement.

Best practice guidance was not always followed to ensure medicines were consistently recorded, stored and disposed of safely.

There were clear recruitment procedures in place; however, these were not always followed fully to help ensure only suitable staff were employed.

Arrangements were in place to deal with foreseeable emergencies, although some staff were not clear about the action to take in the event of a fire.

Staff protected people's rights and acted in their best interests, although they were not always clear about the extent of their role under the Mental Capacity Act 2005. Procedures to use low-level interventions, to support people who could behave in a way that put themselves or others at risk, were not robust.

Most staff had received sufficient training to enable them to support people effectively, although a night support worker had not completed some essential training.

Individual risks to people were usually managed effectively and people were involved in risk-taking decisions. Infection risks were managed appropriately for the size and type of service.

People felt safe living at Sea Gables. Staff used innovative techniques to help people understand safeguarding and protect them from the risk of abuse.

There were enough staff available to meet people's care needs and support them with activities. Staff were appropriately supported in their role by managers.

People's nutritional and dietary needs were met consistently. The home had been adapted to meet people's needs.

Staff supported people to access healthcare services when needed and helped ensure they experienced a smooth transition when they moved into or out of the service.

People were supported by kind, caring and compassionate staff who knew them well. They interacted positively with people and helped boost people's morale and feelings of self-worth through a 'Housemate of the month' scheme.

Staff encouraged people to be as independent as possible, used appropriate techniques to communicate with them and involved them in planning the care and support they received.

Staff respected people's sexuality, privacy and dignity. They supported people to build and maintain relationships with people important to them.

People received personalised care and support from staff who demonstrated a strong commitment to treating them as individuals and putting people at the heart of the service.

People were supported to access the community, take part in a wide range of activities and to lead happy, fulfilled lives. They were encouraged to develop independent living skills by setting personal goals.

Staff promoted choice and were responsive to people's wishes. People felt able to raise concerns and there was an accessible complaints procedure in place.

There was a clear management structure in place and staff were motivated, happy in their work and felt supported by the management.

Staff demonstrated a commitment to the ethos of the service by supporting people in a personalised way to the best of their abilities.

The views of people, staff and professionals were sought and acted on.

Community links had been developed which benefited people and reduced the risk of them becoming socially isolated.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Best practice guidance was not always followed to ensure medicines were consistently managed safely.

Appropriate recruitment procedures were in place, but these were not always followed fully to ensure staff were suitable for their role.

Individual and environmental risks to people were usually managed effectively, although some staff did not fully understand the fire safety procedures.

There were systems in place to protect people from the risk of infection.

Staff used innovative techniques to help people understand safeguarding and to protect them from the risk of abuse.

There were enough staff available to meet people's care needs and support them with activities.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff acted in people's best interests, but were not always clear about the extent of their role under the Mental Capacity Act 2005.

Procedures to use of low-level interventions, to support people who could behave in a way that put them of others at risk, were not robust.

Staff were competent and understood people's needs. However, a night staff member had not received some essential training.

Staff were appropriately supported in their roles by managers.

People's nutrition and dietary needs were met and they received a choice of meals, snacks and drinks suited to their needs.

Staff supported people to access other healthcare services, including routine medical appointments. They also supported people when they moved into or out of the service.

Adaptations had been made to the home to help make it supportive of the people who lived there. The provider was exploring new ways to support people through the use of technology.

Is the service caring?

Good

The service was caring.

People were supported by kind, caring and compassionate staff who knew them well.

Staff encouraged people to be as independent as possible.

Staff used appropriate techniques to communicate effectively with people.

Staff respected people's sexuality and supported them to build and maintain relationships with people important to them.

Staff protected people's privacy and respected their dignity. They involved people and their families, where appropriate, in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support from staff who understood and met their needs well.

Staff treated people as individuals and put them at the heart of the service.

People's care plans contained detailed information about their needs and were reviewed regularly.

People were supported to access the community, take part in a wide range of activities and lead happy, fulfilled lives. They were encouraged to develop independent living skills by setting personal goals.

People felt able to raise concerns and there was an accessible complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

CQC were not always notified of significant events.

There was a quality assurance process in place, but this was not always used effectively to identifying concerns and bring about improvement.

There was a clear management structure in place. Staff were motivated, happy in their work and felt supported by the management.

The views of people, staff and professionals were sought and acted on.

Staff demonstrated a commitment to the ethos of the service by supporting people in a personalised way to the best of their abilities.

Community links had been developed which benefited people and reduced the risk of them becoming socially isolated.

Sea Gables Residential Home

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 1 and 3 October 2018. We then had an in-depth telephone conversation with the registered manager on 15 October as they had been out of the country when we visited. The inspection was conducted by two 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people living at the home and two of their relatives. We also spoke with the providers, the registered manager, a duty manager and eight support workers.

We looked at care plans and associated records for five people and records relating to the management of the service, including: duty rosters, staff recruitment files, accident and incident records, maintenance records and quality assurance records. We also observed care and support being delivered in communal areas of the home.

At our last inspection, in May 2016, we identified no concerns.

Requires Improvement

Is the service safe?

Our findings

There were arrangements in place for managing medicines. However, best practice guidance was not always followed to ensure medicines were consistently recorded, stored and disposed of safely.

People's medicines were kept in individual, locked cabinets and only accessed by staff who had been trained and assessed as competent to administer medicines. At the beginning of each four-weekly medicines cycle, staff receiving the medicines for the next four weeks conducted an audit to check that the quantity of medicines in stock tallied with the number recorded on the medication administration records (MARs). This had been done two days before our visit; however, we found the audit was not accurate and the quantity of medicines in stock did not always tally with the MAR charts. On one case, there were too many tablets in stock and in another case, there were too few. Staff had signed the MAR charts to show they had administered people's medicines as prescribed, but the anomalies meant we could not be assured of this. The staff member responsible for the audit told us it was the first time they had completed the audit and felt they must have made a mistake with the counting.

Medicines that had not been used and were awaiting return to the pharmacy were stored in a secure cupboard. A record was made of these medicines in the 'returns book', but not until they were about to be returned. This meant the medicines in the cupboard were not accounted for until they were collected by the pharmacy. This posed a risk that the provider would not have been aware if any had gone missing or been taken during this period. This was contrary to NICE guidance, which recommends that medicines awaiting disposal should be recorded and stored in a tamper-proof container within a cupboard. Following the inspection, the registered manager investigated the above issues, issued new guidance to staff to help ensure safe medicine practices were followed consistently in future and revised the audit tool used for that purpose.

People told us they could access 'as required' (PRN) pain relief and we saw there were PRN protocols in place to advise staff how and when these should be given. However, for a sleeping pill, we found the PRN protocol was incorrect; it specified a dose of 37mg, when the prescribed dose was only 3.7mg. This posed a risk that the person could receive an unsafe dose, although the staff we spoke with knew the correct dose and records showed the person had never received an incorrect dose. A senior staff member immediately amended the PRN protocol accordingly.

Staff closely monitored the effectiveness of medicines administered to people and where these had adverse side effects or did not appear to be effective, they asked the prescribing health practitioner to review them. For example, one person was not benefiting from a medicine to support their mental health and staff had liaised with the person's GP to have it replaced. Staff also supported people to obtain medicine in liquid forms, when needed. When people wished to take homely remedies, such as cough medicines and vitamins, staff checked with the person's GP to ensure they would not interact adversely with any prescribed medicines. A process was also in place to help ensure topical creams were managed safely and the temperature of rooms used to store medicines and of the medicines fridge were monitored effectively.

There were clear recruitment procedures in place to help ensure only suitable staff were employed; however, these were not always followed. For example, a full employment history was not always provided; this meant the provider was not able to consider whether an applicant's background impacted on their suitability. Following the inspection, the registered manager told us staff had been using an old audit tool to monitor recruitment procedures. They replaced this with the new version that prompted staff to check there was 'a full and continuous employment history' for all applicants.

In all cases, checks with the disclosure and barring service (DBS) had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. There was also a clear process in place to assess the suitability of applicants whose DBS check showed they had previous convictions.

Arrangements were in place to deal with foreseeable emergencies. Since the last inspection, the provider had upgraded their fire alarm system to a 'fully addressable system' that enabled staff to identify the source of a fire more quickly and accurately. The fire alarm system was checked regularly and all staff had completed fire awareness training; however, when we spoke with staff, they were not clear about the correct action to take if the fire alarm activated. All described how they would immediately evacuate people from the building and keep them safe, but each gave conflicting accounts of how and when they would check the building for fire and at what stage they would call the fire service. Following the inspection, the registered manager re-issued guidance to staff to clarify the procedures.

People had practised evacuation procedures and for two people the fire procedures were clearly displayed in a picture based format on the back of their bedroom doors. Each person also had a personal emergency evacuation plan (PEEP) in place that detailed the support they would need if they had to be evacuated.

Other environmental risks to people were managed effectively. Maintenance staff checked the temperature of water outlets every month, including those in people's rooms. In addition, gas and electrical appliances were serviced regularly.

Individual risks to people were usually managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. For example, some people would be at risk if they undertook certain activities in a heightened emotional state. Staff knew which people were at risk and in what circumstances and described how they managed the risk by calming the person or distracting them by offering safer options. The actions described were all in line with the risk assessments documented in people's care files.

One person was living with epilepsy and carried a prescribed rescue medicine with them wherever they went out. A robust support plan had been developed in consultation with the person, their GP and a community learning disability nurse. Staff understood the plan and described the action they would take if the person experienced a seizure. The care plan for another person living with epilepsy highlighted the risks and the signs staff should look out for, but did not include any information about how staff should respond if the person had a seizure. We discussed this with a senior staff member who updated the person's care plan to provide clear advice to staff to call 999 immediately.

People were involved in risk-taking decisions. For example, one person was at risk of becoming unwell in the shower, yet wished to shower independently in the interests of their privacy. Staff had supported the person to understand the risks and the options available. They had agreed that they would wait outside the person's room while they showered, so they could call for help if needed; this empowered the person while giving them privacy, independence and security at the same time.

Staff took a 'safety first' approach to supporting people when travelling in vehicles. For example, one person was known to sometimes become agitated and distract the driver. Arrangements were in place to ensure a minimum of two staff members always travelled in the vehicle and staff were directed to stop the vehicle immediately if the person became agitated. When people travelled independently, staff ensured the person had a fully charged mobile phone with them and noted what they were wearing, so emergency services could be alerted if the person did not arrive at their destination.

Infection risks were managed appropriately for the size and type of service. All areas of the home were clean and staff followed infection control guidance to reduce the risk of cross contamination. Each person had a cleaning schedule for their room and en-suite bathroom. Staff supported people to complete this and to use appropriate cleaning products and personal protective equipment, under supervision. There were also cleaning schedules for communal areas of the home, for which night staff were responsible. Electronic records were kept of all cleaning completed, so managers could monitor and take action if any had not been done. The home had been awarded five stars (the maximum) for food hygiene, following a check by environmental health officers.

People told us, or indicated through their body language that they felt safe living at Sea Gables. One person said, "I feel safe. When I go out with staff, they remind me about looking and listening [for danger]." Another person told us, "Sometimes people get cross and shout, but staff sort it out."

Staff used innovative techniques to support people to understand safeguarding and protect them from the risk of abuse. One person using the service had been appointed as the 'service user lead' for safeguarding. They had been given training, wore a lanyard to highlight their role and had weekly meetings with a senior staff member. The person told us, "People talk to me if they've got any problems." They explained that they would then escalate any safeguarding concerns to the senior staff member. Staff had also experimented with a board game to support people to understand safeguarding and their right to live in an environment that was free from abuse. Staff told us the game had not proved very useful, but had, nevertheless, helped increase people's awareness of safeguarding.

Staff had received safeguarding training and knew how to identify, prevent and report abuse. They were confident managers would respond to any concerns they raised and had contact numbers for the local safeguarding authority should they need to report concerns externally. For example, a staff member told us, "I would go to my manager, I could also go to [the home's safeguarding lead]." Staff described how they dealt with conflict between people, to prevent it from escalating. The techniques described were appropriate and were confirmed by the people we spoke with; they included supporting people to move to quiet areas and to distract them with activities they enjoyed.

One person was at potential risk of abuse from a person who visited them at the home. Staff were alert to this risk and a clear plan was in place to support the person appropriately when the person visited, including arrangements for them only to meet in communal areas where staff could observe interactions.

Suitable systems were in place to protect people's property and reduce the risk of financial abuse. For example, one person was able to withdraw money from the bank independently, but staff supported them by writing down the amount the person wished to withdraw, in case they became confused. Some people had a history of entering other people's rooms and taking personal items. Staff had responded to this by emphasising to people the importance of people's privacy and their personal possessions. One person told us, "I got told off for taking someone's videos. I wrote a contract with [a staff member] about [not] taking videos. It helps me remember the rules." The provider had also provided locks for people's rooms, which some people chose to use.

People told us there were always enough staff available to support them. One person told us, "There's enough staff around if I need them." Staffing arrangements were based on the need for a staff member to be present in the home at all times; additional staff then worked flexibly to support people on an individual basis with activities or events they wished to attend. The provider told us staff worked flexibly to accommodate people's activity preferences. They added: "In the summer they [staff] worked later to support people attend events." A family member confirmed this comment and said, "They [staff] work around the housemates needs. They put themselves out and will vary their support hours [accordingly]."

Requires Improvement

Is the service effective?

Our findings

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). 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. We saw MCA assessments had been completed where needed and best interests decisions had been made and recorded in consultation with relatives and professionals. Staff had made some best interest decisions for medical interventions, for which they were not the decision-maker in law; this showed a lack of understanding of the MCA. The registered manager told us staff had done this to help the person understand the decision, but issued new guidance to staff to clarify the limitation of their role under the MCA.

Where people had capacity, we saw they had signed their care plans to indicate their agreement with the proposed care and support. Family members told us staff always acted with the consent of the person or a family member; for example, one family member told us, "Nothing happens without me knowing about it and agreeing to it." A staff member told us they let people "operate as freely as possible" with the minimum of restrictions.

Staff recognised that people had the right to make unwise decisions and described how they would respond. For example, a staff member told us, "If someone wanted to buy alcohol and I knew they had not done well with alcohol, I'd advise it might not be the best thing or suggest they saved it for a special occasion. If they really wanted to [buy alcohol], I would allow them to, but make sure they have all the right information." Another staff member told us, "If [a person] suggests going for a run around the road, I'd suggest it's best not to if it's busy, but when we got to a quiet road I'd say, 'how about doing it here?'."

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found staff were following the necessary requirements. DoLS authorisations had been applied for or granted where needed. A condition imposed on the authorisation for one person had been followed; however, for another person subject to a DoLS authorisation we found there was a lack of clarity around the use of restraint by staff.

Staff had received a variety of training to support people who could behave in a way that put themselves and others at risk, including physical intervention, positive behaviour support and challenging behaviour courses. However, while some staff described low-level restraint techniques they were confident to use to support one person, other staff who regularly supported the person said they had not been taught these techniques. Although the person had a behaviour support plan in place, this did not specify the techniques that should be used in the community or the level of training required by the staff using them. If the person

needed to be restrained, there was a risk that techniques used by staff might not be effective and could cause harm to the person. Following the inspection, we received a newer version of the person's support plan that would help ensure they were supported in a safe and consistent manner.

At night, only one staff member was available to support people. Most staff who worked night duties had received sufficient training to support people at night; however, a newer staff member had not completed first aid training or epilepsy training. This posed a risk to people, including two people who had epilepsy. When we raised this with the registered manager, they immediately arranged for the staff member to complete this essential training.

In all other respects, staff were competent and had received sufficient training to support people effectively. A family member told us, "I can't fault the care here; it's exceptional." Another family member said, "The staff are so well trained. They are excellent in every way; they always have been."

New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff and the completion of essential training. Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Experienced staff received regular refresher training in all key subjects and had a development plan to enable them to continually improve their skills, including by obtaining vocational qualifications relevant to their role.

Staff told us they felt supported in their roles by managers. Each received regular one-to-one sessions of supervision, together with annual appraisals to discuss their role, their well-being, and any development needs. A staff member told us, "I get lots of support from managers and get enough supervision." Another staff member said, "I've always felt I can always ask questions and be confident in the answers."

People's dietary needs were met consistently. Each person had taken responsibility for preparing the main meal of the day for one day of the week; they told us they enjoyed doing this with the support of staff. One person said, "I like doing cooking. I get my own shopping." Alternative meals were offered if people did not like the planned meal, together with a variety of snacks throughout the day. For example, one person said they didn't want the planned meal of the day, so staff asked what they would prefer. The person said, "Eggs", to which the staff member responded, "Oh, you love eggs, don't you. That's not a problem."

Some people needed special diets to support their needs and we saw these were provided. One person had particularly complex nutritional needs and staff had received training from a specialist nurse to aid understanding; this had then been supplemented by the person's relative, who had an in-depth understanding of the person and their condition. When we spoke with staff, they demonstrated a good understanding of how to meet the person's needs and we saw a recommended fluid restriction was being monitored effectively. Another person had a food allergy and showed us a special cupboard they used to store their food. This helped ensure they did not eat foods that might cause an adverse reaction. A staff member told us they even made "special cakes for people with special diets, so they don't feel left out".

Staff monitored people's health and supported them to access healthcare services when needed. Staff had recognised that one person's mental health was deteriorating and they had supported the person to attend appointments with mental health specialists and to change their medicines to a regime that better supported their needs. Another person was supported to receive regular blood tests to monitor a specific health condition.

Staff provided proactive support to help ensure people experienced a smooth transition, with continuity of care, when they moved into or out of the service. For example, a person who was considering moving to the service had been invited to dinner to get to know the home and meet the people already living there. Two people were hoping to move to services where they could be more independent. Staff had worked with them to develop 'transition plans' to help prepare for such a move. The plans included specific goals that were actively monitored. Each person also had a 'hospital passport' to help ensure their support and communication needs would be known if they were admitted to hospital.

The home had been adapted to meet people's needs. The communal areas of the home had been changed around since the last inspection to provide a dedicated dining room where people were able to eat together. Staff told us this had been done in consultation with the people using the service and was working well. In addition, people were being supported to build a 'games room' as a recreational area and had been given complete autonomy over its design and contents.

The provider was exploring new ways to support people through the use of technology. These included a secure system to enable family members to access parts of their relative's care plan remotely (with the person's consent) to monitor their well-being. In addition, two people were about to start using hand held computers, into which they could speak, to aid communication and allow them to record a daily journal of their activities and achievements.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. Everyone we met spoke positively about the warmth of the staff and the friendly atmosphere they created. People told us they were "happy" or "very happy" living at Sea Gables. One person said, "I like it here. Staff are all nice." They added: "I could talk to staff if I was unhappy and they would let me talk about it."
Another person said, "If I was upset, I could talk to [two named staff members]. They are nice to talk to. They help me make choices."

A family member told us staff knew the people living there "inside out", having supported them for many years. They added, "They are very aware of their special needs." Another family member said staff were "always there if I ever need support myself" and provided an example of how staff had supported them to complete some important documents when they had been unwell. Written feedback to staff from another family member included: "I'm afraid I cannot find the correct words to express my thanks in a satisfactory manner, but I do thank you sincerely for the help that [staff] give to [my relative] which I know is well above what would be expected." The feedback was accompanied by a bouquet of flowers to show the strength of their appreciation.

Throughout the inspection, we observed positive and supportive interactions between staff and people. For example, while a person was being supported to go look through a recipe book to choose the evening meal, the staff member outlined the cooking steps and asked questions to encourage thought and gently steer the person towards a decision.

Staff demonstrated a shared understanding of the need to encourage people to be as independent as possible and provided examples of how they did this on a day to day basis. A family member told us their relative was "more confident" now than when they had moved to Sea Gables. Another family member said of the staff, "They support [people] to be as independent as they can and are there to catch them if needed." A staff member told us, "We promote independence as much as possible, for example around road safety and money awareness; we'll take a step back and let [people] do it where they can." Another staff member described how they promoted independence in the kitchen by reducing distraction and giving a person time to process instructions and prepare meals.

Staff helped boost people's morale and feelings of self-worth through a 'Housemate of the month' scheme. The scheme invited people to vote for a housemate each month and the person chosen then received a reward and a certificate citing the reason they were chosen, for example for being helpful or thoughtful. One person told us, "I got housemate of the month a couple of times. It's nice when you get it."

Staff used appropriate techniques to communicate effectively with people. One person had limited verbal communication but staff had learnt to understand them. Their family member told us this had impressed them and added, "I often ask staff to translate for me now, as they understand him so well." The person also used a small number of signs to help them communicate; although these were not recorded, most staff supporting the person understood and used them regularly. Following the inspection, the registered

manager produced a written list of the most common signs used by the person, to aid communicate with new staff.

People had regular discussions with their key workers, with whom they had built a good rapport. A key worker is a staff member who takes a particular interest in supporting a person to meet and review their needs, goals and aspirations. One person told us, "I have a key worker, she knows me well." Conversations with key workers were documented and action was taken in response to feedback from the person. For example, we saw one person had been making plans with their key worker for their birthday and had been actively exploring a range of options to celebrate it.

Staff recognised, supported and respected people's sexuality. The key worker of one person had worked closely with them to help them understand and discuss a close relationship they had formed with another person. Records showed they had discussed sex, love and relationships in an open way that the person understood. Another person had a large poster from a well-known men's magazine displayed on the wall of their bedroom which reflected their sexual preference.

People were also supported to follow their faith. A family member told us, "Staff here would absolutely support people's religious needs. [My relative] went through a period of [attending a local church] and staff took her there." Another people's care plan specified that they had 'no interest in faith' but observed Christian festivals, such as Christmas and Easter.

Staff supported people to build and maintain relationships with people important to them. Care plans contained information about the person's family members and 'other important people' in their lives. People were supported to visit their families often or to go on holiday with them. One person preferred their family to visit them and staff were happy to accommodate this. Another person told us, "I can phone mum and see her every week."

Staff protected people's privacy and respected their dignity. Staff were clear that they did not enter people's rooms without knocking and being invited to enter. For example, a staff member offered to get an item from a person's room for them, but before doing so asked for permission to go in their room. A family member told us, "[My relative needs a lot of private time and [staff] respect his privacy." People could choose the gender of the staff member who supported them with personal care and the degree of support they received. For example, for one person male staff were directed to wait outside the person's bedroom while they showered and female staff were requested wait in the person's bedroom, but outside of the shower room.

People were involved in developing and reviewing the care and support they received and could access their care plans at any time. Family members told us they had also been involved in discussing their relative's care plans. One family member said, "We discuss [my relative's] support all the time. There's never a need to make big changes as they [staff] make little changes all the time." Written feedback from another family member said, "I think it's really great that we can communicate in such a positive manner together in [my relative's] interests." People were also involved in the recruitment process to help assess the suitability of applicants to meet their needs and in decisions about the décor of the home.

Good

Is the service responsive?

Our findings

People received personalised care and support from staff who understood and met their needs well. One person said, "It's good living at Sea Gables." A family member told us, "[My relative] is not easy, but [staff] manage her well."

Staff demonstrated a strong commitment to treating people as individuals and putting them at the heart of the service. A staff member told us, "You have to adapt [your approach] to each person. The way you work with each person is different." Another staff member stressed that "everybody's different" and needed to be supported in a different way. Staff gave example of how they adapted their approach to meet people's individual needs. For example, one person was sometimes reluctant to take their medicine, so rather than restrict them to a specific time, staff had negotiated a time period with the person's GP, after which the medicines would not be offered. This enabled the person to receive their medicines at a time convenient to them rather than only at the time of the medicine round.

Assessments of people's needs were completed by a manager before people moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives where appropriate. Care plans contained detailed information to enable staff to provide care and support in a personalised way according to people's individual needs, wishes and preferences. They included people's normal daily routines, their backgrounds, hobbies and interests. Where needed, they also contained actions agreed with the person to help ensure their needs and preferences were met.

People's care plans included information in an accessible format using picture prompts. A sample of those that we viewed showed people had been involved in creating them and had been supported to write comments on them.

Staff demonstrated a sound understanding of the support each person needed. For example, one person had a comprehensive behaviour support plan that directed staff where to sit when supporting the person and how to approach them. Our observations showed staff followed this consistently. The care plan included detailed information about potential triggers and support techniques that were effective when the person became agitated, for example using music or talking strategies.

Similar plans were in place for other people who could become anxious or behave in a way that put themselves or others at risk, either within the home or when out in the community. These helped ensure staff responded to such behaviour in a personalised and consistent way. For example, for one person, staff were directed to ensure they were not in a 'heightened mood' before they left the home and to support the person to practise breathing techniques to help calm them. For a person who liked football, staff had developed a yellow card and red card warning system to help them recognise when comments they were prone to make in public could put themselves at risk.

People were supported to take part in a wide range of activities, including work placements in the community and college courses to learn new skills. Other activities included acting groups, samba dancing,

special Olympics and swimming. A family member told us how proud they and their relative were when they won a gold medal in the special Olympics recently.

We heard continuous discussions between people and staff about the activities they would like to do. Two people decided they didn't wish to do their planned activity for that day and staff responded by making other suggestions with gentle encouragement for them to "keep active". Family members told us staff went out of their way to ensure their relatives enjoyed active, fulfilled lives. One family member said, "If [people] want to stay out until 11 at night, then they can. For example, [my relative] wanted to go to [a music event] and staff were creative with the [allocated support hours] before and after, so they could support them attend." Staff had also supported people to go on a 'house holiday' together, which people spoke positively about and had clearly enjoyed. Two people had also been supported to go on another holiday together.

People spoke enthusiastically about individual goals they were working towards to enhance their independence and well-being. These were monitored through goal charts to help them see how much progress they had made. Since the last inspection, everyone living at the home had taken positive steps towards achieving their goals. For example, one person told us, "I want to go out on my own. I'm working towards it bit by bit." Two other people had set personal goals of moving to flats where they could live more independently and staff were supporting them in liaison with social care professionals. One person told us they had been helped to budget effectively and to use the bank independently. Another said, "I can go to shops on my own now and they [staff] helped me to use buses on my own."

Staff promoted choice and were responsive to people's wishes. For example, one person had expressed a wish to shower in the evenings rather than the mornings as they found it less tiring. Staff supported this choice and understood the reason for it. Another person told us, "[Staff] help me make [meal] choices and I ask them to write down what I want to cook." Other people had chosen not to have regular checks during the night and this was respected. A family member said of their relative, "She makes choices and is fussy now with things she eats. She never used to be, but she is now because she has choices."

Staff knew how to access support from healthcare professionals if they needed further guidance about supporting people at the end of their lives. People living at the home were younger adults, for whom discussions about end of life care were not a priority. Staff had started to have conversations about this with one person and were planning to follow these up by talking to family members.

People felt able to raise concerns and an accessible, picture-based, complaints procedure was in place, including details of who to contact if the person was not satisfied with the outcome. A family member described staff as "accessible" and said, "If I needed to make a complaint I'd feel comfortable going to them."

Requires Improvement

Is the service well-led?

Our findings

People enjoyed living at Sea Gables and felt it was run well. One person told us, "I'm happy living [at Sea Gables]." A family member told us, "I can't praise this place enough." Another family member told us they were "delighted" with the service and added: "I think it's the best home on the Island and I've seen a few of them." Written feedback from the manager of another home complimented staff for being "professional and alert" during a community event at which staff were supporting two people.

Although people were happy with the service, we identified some areas for improvement. The registered manager usually notified CQC of significant events, although we identified that an altercation between people, which had led to an allegation of abuse, had not been notified to CQC. Staff had, however, taken appropriate action and had notified the local safeguarding authority and the person's relative. This demonstrated openness and transparency. There was also a 'Duty of Candour' policy in place to help ensure staff would act in an open and transparent way if things went wrong, although there had been no incidents that met the threshold for action. Following the inspection, the registered manager issued additional guidance to staff to help ensure all CQC notifications were made promptly in future.

There was a comprehensive quality assurance process in place. This was based on a range of audits conducted by staff on a daily, weekly or monthly basis; they included care plans, staff files, medicines, infection control and safeguarding. However, the audits were not always effective in identifying concerns and bringing about improvement. For example, we found a recent medicines audit was inaccurate, so had not picked up discrepancies in the medicine stock; the staff recruitment audits were being completed on out of date forms, so had not picked up the lack of a full employment history for some staff; and the care plan audits had not identified the lack of information about the use of restraint to support one person. Following the inspection, the registered manager took immediate action to address all of these issues.

The quality of the support delivered by staff was monitored through regular 'spot checks' of staff. These were used to assess whether staff were supporting people effectively and in line with their care plans. There was a process in place to identify common themes or individual learning points from complaints or feedback from people and staff.

There was a clear management structure in place, consisting of the providers, the registered manager, the deputy manager and senior staff. A 'house supervisor' was nominated each day and support staff understood their roles and worked well together. Staff were organised and completed delegated tasks in an efficient way that helped ensure people received effective support. They used 'handover meetings' to aid communication between shifts and ensure continuity of support for people. In addition, senior staff were available on call to provide advice and guidance out of hours.

People benefited from a service where staff were motivated, happy in their work and felt supported by the management. Comments included: "It's the best place I've ever worked. It's the most rewarding thing I've ever done"; "I can't tell you how good [the managers] are, for any problems, big or small"; "It's a good place to work, [managers] listen to you"; "It's fantastic here. Everyone is so supportive, I can't fault them"; "If

someone rings in sick, someone is always ready to step in [to cover]" and "I really love it here, it's the best job I've ever had".

People's views were sought in a range of ways, including at well-attended 'house meetings'. These were held every month and advertised to people using a picture-based agenda to encourage participation. A person told us, "I've been to a house meeting. We talked about the new games room. We can choose what goes in there, I picked trains." People and their families were also invited to complete questionnaire surveys. These were also picture-based and it was clear that people had been supported to complete them. The results were analysed by an independent company to identify any changes or improvements to the service. These were then published in an easy-read format. For example, one person had requested a new bed and this had been ordered; another person had asked to move rooms and this was to be actioned as soon as a room became available.

The providers were actively involved with running the service and provided a high level of support to the manager. One of the providers told us, "I get a feeling [when I visit] that I can sense and pick up on any tension and discuss it with the management team." The providers demonstrated their appreciation of staff in a range of ways, including by nominating them for awards at local care events; for example, one staff member had recently been nominated for, and received, an award in the category "Best newcomer to care".

The provider had a vision statement that expressed a commitment to providing "high quality care which focuses on a personalised approach to maximise independence. One of the providers told us they also wanted to make the environment "as relaxed and comfortable as possible and to put people first, for example in making choices about what they eat and how they spend their time". They added, "Staff that work here need to know the people [living here], and flexibility in the hours [they work] come first." When we spoke with staff and observed the way they supported people, it was clear they understood the ethos and vision of the service and were committed to supporting people in a personalised way to the best of their abilities.

Staff were fully engaged in the running of the home and felt able to make suggestions for improvement, including during staff and key worker meetings. A staff member told us, "[Managers] are always asking what do you think about this or that; I definitely feel included." Records of meetings showed that action points were identified and monitored through to completion. Staff were also invited to a complete questionnaire survey, the results of which were published and had led to changes. For example, staff had identified the need for improved communication and this had been addressed through a monthly newsletter; staff had also asked to spend time with people's key workers to gain a better understanding of people's needs and arrangements were being put in place to accommodate this.

The registered manager took account of feedback from other professionals; for example, following a recommendation from the local authority, they had created a simple guide for new people moving to the service. In addition, an audit of medicines by an external pharmacy had led to improvements; for example, it had identified the need for hand-written entries on MAR charts to be counter-signed by a second staff member and we saw this had been done; it also identified the need for the use of homely remedies to be checked with the person's GP and we saw this had been done too.

The registered manager had access to a wide network of health and social care professionals, together with other resources for support and guidance. For example, they represented providers on the local safeguarding adults board, which gave them access to the latest guidance about protecting adults at risk of

abuse and was a member of the local care homes association.

Community links had been developed which benefited people. These had been instrumental in raising funds for a hot tub and helping secure community work placements for people. There were also positive links with people who used another service operated by the provider; the two groups met at community events, festivals, summer barbeques, fetes and Christmas parties. This helped people develop a wider support network and reduced the risk of them becoming socially isolated.