Community Homes of Intensive Care and Education Limited

Albert Lodge

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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

Albert Lodge is a 'care home'. People in care homes receive accommodation and personal care as a 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 21 August 2018 and was unannounced. This was the first inspection of the service following its registration in October 2016.

Albert Lodge provides personal care and accommodation for up to six adults with learning disabilities and mental health illness. Some people were also living with behaviours that may cause harm to themselves or others. At the time of our inspection there were five people using the service.

People living at the service were not socially excluded due to their behaviours because they were enabled to live their chosen lifestyles with intensive specialised care from staff. The service had a communal kitchen, dining/lounge room and garden.

There was a registered manager in place. 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.

People told us staff were extremely kind and caring, and their privacy and dignity was upheld and promoted. We received consistently positive feedback which showed us that people felt highly valued and respected.

Care and support was recorded in a very person-centred way with excellent emphasis on how people wished and needed to be supported. Staff fully involved people with support plans and care reviews. People were encouraged to make decisions about how their support was provided and staff were very respectful and understanding of people's rights and choices.

The service was exceptionally responsive to people's individual needs and wishes. This included innovative 'family work' sessions, enabling people to achieve their potential. There was a strong ethos of inclusivity that was promoted by staff. Independence was encouraged and supported with the aim of people moving on to supported living arrangements.

People were safeguarded from avoidable harm. Staff adhered to safeguarding adult's procedures and reported any concerns to their manager and the local authority.

Staff had been recruited following safe policies and procedures, and there were sufficient numbers of staff employed to make sure people received the support they needed during the recovery process. Staff received appropriate training and support that enhanced the knowledge, values and life experience they

had already gained. This included training on how to protect people from the risk of harm and on the provider's recovery programme.

Staff assessed managed and reduced risks to people's safety at the service and in the community. There were sufficient staff on duty to meet people's needs. Staff understood and practiced the principals of Positive Behavioural Support (PBS). A method of supporting people who display, or are at risk of displaying, behaviour which challenges.

Staff were able to recognise that harmful behaviours were also a form of communication and staff had been trained to respect how people communicated their feelings. The provider gave people the opportunity to share their views by training staff to understand people's communication styles and collecting detailed data about people's moods, facial expressions and body language.

Safe medicines management was followed and people received their medicines as prescribed. Staff protected people from the risk of infection and followed procedures to prevent and control the spread of infections.

People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Recovery (care) plans described the person and the level of support they required to reach their individual goals. Plans were reviewed regularly to ensure they remained an accurate record of the person and their day to day needs.

People were supported to explore new interests and gain confidence.

Staff supported people to eat and drink sufficient amounts to meet their needs. Staff liaised with other health and social care professionals and ensured people received effective, coordinated care with regards to any health needs.

Staff applied the principles of the Mental Capacity Act 2005 and Mental Health Act 2007. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. An appropriate environment was provided that met people's needs.

People told us that the staff provided very good care and support in respect of their health and wellbeing. We saw excellent evidence of the positive impact this had on people's lives, with emphasis on the promotion of people's rights and independence. Staff and people had developed very caring, strong, meaningful relationships.

The service placed a strong emphasis on a 'person centred approach' to enrich people's lives. This meant care and support was centred on people's individual needs and wishes.

Health care professionals told us staff had an exceptional understanding of people's beliefs, values and how they wished to be supported. Feedback from those outside the home was excellent regarding all aspects of the service.

People told us they were aware of how to express concerns or make complaints and felt their comments would be listened to. People were given the opportunity to share their views about the service provided.

The feedback we received and our observations on the day of the inspection demonstrated that the home was well managed. The registered manager and staff displayed a clear vision and consistent values in relation to the provision of care and the ethos of the service. The registered manager carried out audits to ensure people were receiving the care and support they required, and to ensure the safety of the premises.

People using the service, staff and external professionals were complimentary regarding the registered manager's leadership and the overall management of the service.

The registered manager had adhered to the requirements of their Care Quality Commission registration, submitting notifications about key events that occurred. This meant we had sufficient information to enable us to monitor the safety of the service.

An inclusive and open culture had been established and the provider welcomed feedback from staff, relatives and health and social care professionals in order to improve service delivery. A programme of audits and checks were in place to monitor the quality of the service and improvements were made where required.

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 were protected against abuse by staff who understood their responsibility to safeguard people. Risks associated with people's needs were assessed and action was taken to reduce these risks.

Medicines were managed safely. The provider's recruitment process ensured appropriate checks were undertaken to check staff suitability to work with vulnerable adults.

Staffing levels were based on an assessment of people's individual care and support needs.

Systems were in place to ensure that ongoing learning took place when there were concerns.

Is the service effective?

Good

The service was effective.

People were always asked for their permission before personal care and support was provided. Where needed people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA).

Staff received supervisions, appraisals and training to support them to provide effective care for people.

People were supported to ensure they received adequate nutrition and hydration. Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring and supported their independence.

People were involved in decisions about their care and the home.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive

People's care records contained extensive, person-centred information which helped to support an excellent standard of individualised care and promote people's individual goals and self-esteem.

People had access to a range of social activities which they enjoyed and people were encouraged to take part in new areas of interest. Staff worked with people in creating opportunities where they could engage in new things.

People were very well supported by staff to develop themselves in their recovery and their move to independence. Staff were creative in how they supported people to maintain important relationships with family and friends and this sometimes involved educating them in the hurdles people can face in recovery.

There was a clear process in place to deal with any complaints or concerns if they were raised and this was followed. There were many examples of how the service was constantly trying to improve how they responded to people as individuals, in a manner that was professional and respectful and non-judgmental.

Is the service well-led?

Good ●

The service was well led.

The provider notified CQC of significant events, such as safeguarding, damage to property and staff injuries; to enable us to monitor the safety of the service.

Systems were in place to ensure a quality service was being provided and to drive continuous improvements.

Staff felt supported and confident to raise concerns with the manager who they felt would take all necessary action to address any concerns. The provider's values were clear, understood and demonstrated by staff.

People, their families and staff were involved in developing the service.

Albert Lodge

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 21 August 2018 and was unannounced. Two inspectors carried out the inspection. This was the first inspection of the service following its registration in October 2016.

We had not requested a PIR (Provider Information Return) prior to the inspection. 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. However, we reviewed other information we held about the service, including statutory notifications submitted about key events that occurred at the service. A notification is information about important events which the service is required to tell us about by law.

We spoke with the registered manager, deputy manager, area manager and three members of support staff. We also received feedback from two professionals before the inspection and spoke with four at the time of the inspection.

Due to our desire to maintain people's well-being we only interacted briefly with three people living at the home, others expressed their right not speak with us. We observed interactions between staff and people using the service. We reviewed care records and other related documents, plus staff records such as supervisions. We reviewed medicines management arrangements and records relating to the management of the service, including policies and procedures.

Good

Is the service safe?

Our findings

People confirmed they felt safe living at the service. One person told us, "Yes I am safe."

People were protected against the risk of harm and abuse. Staff were supported to undertake training in safeguarding and were aware of the steps to take if they suspected abuse, who to report this to and how to escalate their concerns. One staff member said, "The nature of the service means there are always safeguarding referrals to be made. We get plenty of practice doing them and all staff know the importance of it". Another staff member told us that they received practical support and guidance from senior staff when first raising safeguarding issues and referring them on to appropriate agencies.

Handovers took place three times a day which ensured any potential concerns were shared with staff to ensure repeat incidents were minimised and where necessary changes were made to the delivery of care in a timely manner. Staff confirmed they felt comfortable raising any concerns with the registered manager.

The service had developed risk management plans to protect people from identified risks. We reviewed the risk assessments and found these identified the risk, what the impact would be on the person and how staff could support them to minimise the risk. We also found risk management plans were regularly reviewed with people where appropriate. Risk management plans looked at all aspects of people's lives and included, for example, finances, eating, hygiene, medicines and the environment. Records relating to risk management plans were kept securely with only people with authorisation having access to them.

People received care and support from staff who learnt from incidents and accidents to minimise the risk of repeat incidents. Records confirmed all incidents were recorded and fully investigated, with the relevant healthcare professionals informed. For example, we noted one record whereby following an incident control measures were updated and changes to the risk assessment were made. All staff had received specific behavioural management training to respond safely to people who were engaged in behaviours which others may find challenging.

Support plans were clearly focused on the rights of individuals, their right to self-determination and a life at the home free from discrimination. There were completed sections on people's relationships and social networks; living skills and independence, identity and self-esteem, in addition to trust and hope. Our observations on the day of our inspection and our conversations with visiting health and social care professionals confirmed people were treated with respect and not discriminated against because of their backgrounds or behaviours. People's support plans outlined the barriers to a fulfilling life that the person might face and how they might be resolved or reduced.

All but two of the people living at the home's finances were managed by appointees. One person managed their money independently but made potentially unwise decisions where and when to spend it. There was an acknowledgement in the support plan that this was their right but there was guidance for staff to help the person make wiser and safer choices. Another person was prone to lending money to others inappropriately. A safeguarding alert had been raised and staff had put in place measures to help the person

to become more assertive and not use lending money as a form of befriending.

The premises were not purpose built but did not present significant difficulties in evacuating people in the event of an emergency. We noted there were Personal Emergency Evacuation Plans (PEEP) in place, which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood. There was also up to date documentation related to the safety and suitability of the premises. For example, nurse call bell maintenance and water temperature monitoring.

People received care and support from sufficient numbers of suitable staff to meet their needs. People told us they felt there were enough staff on duty at any one time to support them and keep them safe. One staff member told us, "Yes, there are enough of us. Sometimes it can get busy, especially if someone becomes upset or aggressive but most of the time it's fine". Another staff member said, "Even if I'm in charge I can usually spend an hour each shift with each person. If I'm busy I can always ask another staff member to do it". Our observations on the day confirmed this. The registered manager explained staffing levels were flexible to meet people's changing needs.

Records confirmed the provider had undertaken robust employment checks to ensure the suitability of staff employed. Staff records contained two references, work history, an application form and a Disclosure and Barring Services (DBS) check. A DBS is a criminal check, employers undertake to make safer recruitment decisions.

People were protected against the risk of unsafe medicines management. We spoke with a senior staff member about medicines management, how medicines were acquired, stored, dispensed and disposed of. We also examined the provider's medication management policy. Evidence showed there was regular, ongoing staff competency checks. Training was also undertaken and updates completed annually. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff signed (Medicine Administration Records (MARs) charts only when the person had taken their medicine. Medicines were dispensed directly from the treatment room without the use of a trolley, which was deemed unnecessary. The storage and disposal of medicines were managed safely, in accordance with the provider's policy. We noted stock balances were kept to a minimum and safe disposal procedures were in place.

We looked at the MAR charts for all people living at the home. There were no gaps in these records. All MARs contained relevant information, such as photographs for identification purposes, whether the person suffered from allergies and how they preferred to take their medicines. Medicines were safely stored in locked cupboards. Medicines requiring refrigeration were stored in a lockable fridge which was not used for any other purpose. The temperature of the fridge was monitored daily.

Medicines given on an 'as needed' basis (PRN) were managed well. PRN protocols were in place for all medicines taken this way; they outlined how, when and why they should be taken and included maximum doses over a 24-hour period. Where a person could be given varying numbers of tablets, for example one or two painkillers, this was clearly recorded on MARs. People at risk of experiencing pain were frequently assessed; care plans gave information how pain manifested itself in each person. Records of all PRN medicines administered for mental wellbeing were sent to the Positive Behaviour Support team (PBST) for analysis to establish patterns and causality, such as triggers to behaviours that could challenge others.

Staff encouraged people to be involved in the monitoring of therapeutic medicines they were prescribed, to ensure concentrations of the medicines were safely maintained. This was done either in the form of blood tests or in monitoring the person themselves, for example, glucose levels for those living with diabetes. We

also noted there was clear guidance for staff concerning the management of people taking all other types of medicines, for example mental wellbeing medicines. These included when to offer the medicines and the signs and symptoms of potential side effects. No-one living at the home managed their medicines independently and no-one received their medicines covertly, that is without their consent or knowledge.

We looked at medication audits undertaken by the provider. They were conducted both weekly and monthly. They looked at aspects of medicines management, such as ordering and disposal. We noted previous areas of concern, such as overstocking of medicines, had been identified and dealt with promptly. There had been two recent medicines errors. Both were investigated promptly and remedial action taken in line with the provider's policy.

Where a person was an insulin dependent diabetic. There was evidence of good care day to day, such as referrals to podiatry for foot care and regular eye checks to maintain health. The person administered insulin themselves and with supervision recorded their blood glucose levels appropriately. There was guidance in the support plan and MAR chart to aid staff in the management of possible emergencies. For example, the support plan described the symptoms and management of hypoglycaemia and hyperglycaemia. The staff we spoke with understood their responsibilities in this area.

People were protected against infection as the service had systems and processes in place to manage those risks. The service undertook regular cleaning of the building and people were supported to ensure their own environment was clean and tidy. Staff told us they had received training in infection control and records confirmed this. The environment was clean and odour free. There were risk assessments in place regarding areas where infection prevention was paramount, such as the management of sharps and laundry. There were also monthly infection control audits, which had identified areas for improvement, such as the need for a revised cleaning schedule, which had been completed.

Good

Is the service effective?

Our findings

People's initial needs assessments reflected good practice guidance and included the person's expected care outcomes whilst living at Albert Lodge. The information we saw demonstrated that staff were aware of good practice guidance and current legislation in respect of people recovering from and living with mental health needs. Staff had lead roles such as medication, health and safety lead and physical health. These members of staff were responsible for ensuring all staff were aware of good practice guidance.

Upon commencement of their role, staff members were supported to complete a comprehensive induction programme that covered; job role, information about the visions and values of the organisation, duty of care, principles of safeguarding, health and safety and equality and diversity. The provider had systems in place to support staff with completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. Each staff member was supported to complete a competency assessment in all areas, which was subsequently signed off by senior staff when they were deemed as competent. We asked new staff about the induction they received when starting employment. One staff member said, "It was great. I'm new to care but the induction was brilliant. I shadowed staff a lot and learned a lot there as well as the training I got." We asked staff about the managerial support they received. Another staff member said, "We get supervision every other month. I can say what's on my mind then but it's such a small service we're talking all the time."

The service had an embedded culture that encouraged and empowered staff to reflect on their working practices through regular team meetings, supervisions and annual appraisals. Support received by staff was proactive. Staff informed us they reviewed their work performance to identify areas of improvement and areas that had worked well. One member of staff said, "The supervision works in a cascade system. That way staff are speaking to people they're working with and know the day to day issues. Anyone can speak to [name] (manager). The door is always open." Another said, "We get supervisions monthly, more or less. It's about me and how I'm managing. If there's anything at all I want to bring up I know I can." Supervision records were up to date and contained the areas discussed, actions to take, whose responsibility this was and the time scale given for achieving these. This meant that people received support from staff who learned from mistakes, sought guidance to increase their knowledge and skills and strove for improvement.

Part of the home's ethos was to support people to move on to independent living. For example, in the last twelve months, two people had moved on from Albert Lodge. Another person has been supported to keep their environment clean, budget and cook for themselves and will be moving to supported living.

The service offers support for people to become more independent and offer a stable living environment. For example, where frequent checks are needed where people self-harm, this was discussed with people as they found it was intrusive, a walkie talkie was purchased to use instead.

Where homelessness has been an issue for people they now see Albert Lodge as their first home.

People were supported by staff members that had access to comprehensive training to further their knowledge and enhance their skills. Training was delivered and tailored to the individual needs of staff. Staff spoke positively about the training they received and confirmed that they received frequent training, which they put into practice. One staff member said, "The training is constant really. We do it on line or get people in from outside." Another staff member told us, "The training is done by staff experienced in the field. It's not just someone reading from a PowerPoint presentation. For example, we get the Positive Behaviour Support team (PBST) in to do training, support and reflective practice." Records confirmed what staff told us, we identified staff training included, safeguarding, MCA, DoLS, infection control, management of behaviours that could challenge others, management of schizophrenia and food safety. This meant that people received support from staff who delivered care following up-to-date practices.

People were empowered to make positive choices to maintain a healthy lifestyle. Staff supported people to gain the tools to make decisions about their dietary requirements, encouraging them to gain clearer awareness of dietary choices and understand the impacts of those decisions. For example, if people had a diet which had direct impact on their behaviours, they were encouraged to understand and where possible avoid foods that triggered negative behaviours.

People living at the home were encouraged to cook for themselves wherever possible, with staff assistance if necessary. Some people living at the home were very enthusiastic about this and kept recipes of their own. There was a 'Healthy Eating Corner' which contained advice and literature for people about how to achieve a balanced diet. There were food charts in place for those whose food intake was a concern, either because they ate little or overate. These were used to inform actions taken to improve the person's nutritional state. Staff were on hand to support people to prepare food that met their dietary needs, requirements and reflected their cultural needs. Meal times were flexible and people chose where and when they wanted to eat. This meant that people could take ownership of their wellbeing and their independence was encouraged.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at care plans in the light of consent and capacity. People had received mental capacity assessments where this was appropriate as part of their decision-making care planning and had sought the consent of people with capacity before acting. It was clear the provider's focus was on facilitating people to make some choices for themselves whenever possible and to support people to avoid potentially risky or unwise decisions where possible. For example, drinking alcohol which could lead to aggressive or violent behaviour for one person. Staff had worked to discover that low mood and contact with family could sometimes trigger alcohol abuse. As a result, signs were used on the door to relay people's mood to staff. One person's support plan read, "These are happy and angry signs and relate to my cravings for alcohol. I will put these on my door to show when I need more support from staff".

We asked staff about issues of consent and about their understanding of the MCA. All staff members we spoke with could tell us the implications of Act and of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. No-one at the home was subject to DoLS authorisation on the day of our visit.

However, we saw people had been involved in best interest meetings regarding capacity and their understanding of medicines and food. These were ongoing as it was acknowledged people can change depending on their mental wellbeing.

People confirmed they could make choices about the care and support they received and had their choices respected. People came and went from the home throughout the day sometimes with staff and other times alone. Some people had agreed to having their bags searched on return but they could also refuse this. They had made contracts with staff as they could sometimes make poor decisions regarding their wellbeing. Other people had agreed to having a breathalyser test before they were offered their medicines. Staff had found that this was sometimes positive although the person stated they had not drunk anything. Staff chose to test this out as they believed the person yet the equipment stated otherwise. Staff tested the breathalyser themselves after a cigarette as research showed this could lead to a false positive. After several trials the team found that smoking before using the breathalyser led to a false positive. The contract with the person was amended to reflect this and a plan put in place for the person to either not smoke before they were offered their medicines, or if the test was positive they were asked to return in half an hour to retry it.

The service had an embedded culture of coordinating and planning people's care collaboratively with other healthcare professionals to ensure people received the best possible care. People who had specific healthcare needs, were supported to access specialists in that field to ensure they received the best care possible. For example, clinical psychologists, physicians, mental health nurses and links to professionals within the LGBT (Lesbian Gay Bisexual and Transgender) community. We spoke with four such external professionals during our visit; all confirmed people were referred appropriately to them, in line with current legislation, guidance and evidence based practice. There were bi-monthly meetings with the positive behavioural support team, which was a meeting with the manager and clinical lead to discuss any concerns. The idea is to be proactive before people reach crisis point. This meant that the care people received was tailored to their individual needs and ensured continuity of care from familiar healthcare professionals.

Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. The manager and staff were aware of equality and diversity issues. There was equality and diversity information for all to see at the entrance at the home. We could see that people were receiving care and support which reflected their diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there which included age, disability, gender, marital status, race, religion and sexual orientation. This information was appropriately documented in people's care plans where needed. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. These principles were also applied to staff who worked at the home.

Good

Is the service caring?

Our findings

The service was good at supporting people to express their needs and preferences so that people received the care they needed and wanted. Care plans we reviewed had an exceptional level of detail within them, including what activities people enjoyed; sleep patterns, foods they liked to eat, medical condition action plans, and daily records which included monitoring of people's emotional state on each shift.

Staff spoke very passionately about the service and it was evident they cared deeply about the people they supported. Each person had member of staff assigned as a key worker and key worker report templates were tailored to support people's individual needs, preferences and, for example, what was important for each person and the desired outcome. There was evidence of how the service focused on people's strengths and celebrated people's achievements. This was used to drive the service forward and make plans for the future.

There was a calm and inclusive atmosphere in the home. Staff we spoke with were knowledgeable about the people they were caring for and could explain to us people's individual needs and requirements. It was evident staff saw people as individuals. Staff were responsive to people's needs and addressed them promptly and courteously. It was evident all staff knew all people well; for example, staff knew people's daily routines without referring to documentation. Those at risk were monitored closely but discreetly where necessary; for example, those at risk of self-injury.

There were a number of external professionals involved in people's care and support, all of whom regularly met with the people and discussed the future. An external professional advised how one of the best attributes was how the staff promoted the atmosphere in the home, which they described as 'homely' and 'so caring'. We found the atmosphere at the home was very calm and relaxed. People using the service were very much at ease with the staff. A person said, "I feel very at home here with everyone, it's all good, really good."

Our observations demonstrated that staff treated people with great kindness, respect and empathy. Staff also understood and recognised when people needed to work independently and when and how people needed to work through their emotions, distress, challenges and taking responsibility for day to decisions. This included being respectful of decisions that staff might not feel were appropriate however, staff were mindful and respectful of people's rights and choices. This showed that people had choice and control over their lives and that staff responded to them expressing choice in a positive and supportive manner.

Each person had a positive behaviour support plan that outlined what they needed to be happy and settled living at the home. For example, if a person was living with an anxiety disorder and social phobia, staff were sensitive to this and were guided by the individual on the amount of social and professional contact they wanted. Medicines were offered away from clinical areas as requested. An example of people's 'Trust and Hope' support plan contained information about the person's beliefs concerning what constituted independence in their eyes. Issues such as housing and their future living at the home were discussed.

People's rights to privacy and dignity were embedded in staff practices and the culture and values of the service. Staff understood it was a human right to be treated with respect and for people to be able to express their views openly and to feel listened to. Staff gave examples of how this respect transitioned into supporting people with daily life choices and 'really listening' and 'understanding' what people faced each day. Staff received training on 'working in a person-centred way', equality and diversity and communication which encompassed people's rights, choices and standards pertaining to privacy and dignity. These elements of care were threaded through people's support plans to support staff's knowledge and skills in understanding and respecting people's rights and values.

From speaking with staff, we could see that people were receiving care and support which reflected their diverse needs in respect of the protected characteristics of the Equality Act 2010 that applied to people living at the home. This included age, disability, gender, marital status, race, religion and sexual orientation. This information was documented in detail in people's support plans. Staff were committed to ensuring people were treated fairly as individuals and for people to be protected against discrimination through their work practices and beliefs. This was apparent through discussions with them, our observations and recorded evidence.

People were encouraged to maintain relationships with friends and family members. Staff regularly communicated with people's family members and always welcomed relatives to visit the service. There was an example where staff went above and beyond supporting a person to visit family which they were unable to do alone due to restrictions placed in the under the Mental Health Act. Staff supported the person in their own time.

Staff told us people's achievements and goals were celebrated in the home, and (with people's consent) in the provider's newsletter and intranet. We saw positive outcome files for each person which contained information about events which had been important to them for example certificates gained on college courses.

The registered manager was aware of the Accessible Information Standard (AIS). For example, they told us that they could produce easy read and large print versions of information for people if needed. The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Records were stored securely and staff told us how information would only be shared with outside agencies where appropriate. The registered manager had details of advocacy services that people could contact if they needed independent support. Advocates are people who are independent of the service and who can support people to make or express decisions about their life and care. Partnership working with stakeholders was evident to fully support people in the home and within the community. We saw how staff were fully involved and supportive of people's wishes and needs to maintain and forge links with the 'right' organisations to support people's development. This was a view shared by health professionals who had an involvement.

Outstanding ☆

Is the service responsive?

Our findings

People who used the service and professionals considered the care to be exceptionally responsive. People told us they had a recovery (care) plan in place and confirmed they had been consulted and their individual goals towards recovery and becoming more independent. They used words such "valued" and a sense of "worth" in their descriptions of being involved.

Staff told us that everyone's recovery plan was different and sometimes needed some innovations to ensure they could meet the goals people had for recovery. For example, the person and staff educating family members on the issues people had in their recovery and how they could all work together to support them.

The service has been responsive to people's needs and requests and has helped them access educational courses at local colleges. They have also accessed courses at the Recovery College a local NHS imitative to increase people's knowledge and skills about recovery and managing their own mental health.

A health care professional said, "There is a strong ethos of patient centeredness and this runs through the home. People are encouraged to develop their skills with a clear and explicit aim to maximise each individual own potential." A second healthcare professional said," Albert Lodge continues to provide excellent care to people. Despite the challenges they face they are always positive and never lose their sense of humour. It's a pleasure to care coordinate for people here." Other comments included, "The staff have the ability to respond to events and changes in people's lives." "This is one of the better homes (of this type) that I visit. It doesn't matter who is in charge, they all know the people here really well." Another professional said, "It's more of a collaborative approach here I think. The staff understand the people here so well; they're very tuned in. It makes my work a lot easier. It's not really a case of me giving guidance and they follow it. They are the experts on the people living here and we work with that." A third professional told us, "Some places we visit, the staff are mostly in the office, but not here. It's partly because of the layout of the home but mainly because staff want to spend time with people."

Staff members went above and beyond providing person centred care to meet the wishes of a terminally ill person to stay at Albert Lodge. The staff, despite not receiving external support cared for the person as they had wished, in their home. The staff went above and beyond working extra shifts to ensure the person received support and care 24 hours a day. Their dedication and care was acknowledged by the provider writing to each member of staff, thanking them for their commitment and care at such a difficult time. This was further confirmed in the team meeting minutes of February 2018. "Staff did an amazing job looking after [name] in their last days with their dignity and respect being maintained. There have been lots of compliments on how staff managed this."

We looked at people's support plans to ascertain how staff involved people and their families with their care as much as possible. The plans showed staff had used innovative and individual ways of involving people and their family, friends and other carers in their care and support plans. People said they felt consulted, empowered, listened to and valued. Support plans and risk assessments were discussed and agreed with people or their representatives. Records of contact with family members were kept and there were regular,

formal reviews of care to which relatives were invited. Each person also had a keyworker who met with the them monthly to discuss recent events and formulate a plan of support together for future use. At the key worker meetings conversations held were meaningful and people were encouraged to share their views on specific areas, such as, choice and involvement of key worker and social activities. People felt the staff listened to them and that their views and opinions mattered. People told us the staff changed things when they asked them to or changed as their needs changed.

Arrangements for social activities, and where appropriate, education and work, are innovative, meet people's individual needs, and follow best practice guidance so people can live as full a life as possible. There were examples of activities that people had chosen such as charity events for mental health, days out and cooking. People had attended music venues with staff or families. The service has gone the extra mile to find out what people have done in the past and evaluates whether it can accommodate activities, and tries to make that happen. For one person who could be quite solitary, staff had been encouraged them to pursue their passion for singing and as a result they had entered the provider's talent contest.

The recovery plans included information that described the person's personality, their individual care and support needs (including any specific communication needs), their medical history, their interests, their capabilities and their previous lifestyle. Staff told us, because they were a small team and worked with people regularly, they got to know them very well. This helped them identify 'early warning signs' indicating that people were unwell so additional support could be requested. A health care professional told us, "Staff are all welcoming with no exception, communication is good and knowledge of my patients is thorough. They succeed in managing difficult situations to safe conclusions. It is a pleasure to work with this team." People completed questionnaires at various stages of the programme to monitor their recovery.

Information about people was shared effectively between staff. A staff handover meeting was held prior to each of the three shift changes each day. Staff told us they shared information about how people had spent their day, changes to medical conditions or care needs and details of planned activities or appointments. We sat in a handover meeting and confirmed the information was handed on to the shift coming on duty by the senior member of staff. This meant staff received up to date information about people's needs immediately before the beginning of their shift. People's choices and preferences were documented. The daily records we looked at were person centred; an insight into people's daily lives could be obtained by reading them.

Due to concerns with a local health service and the lack of support and care people received at the home, the registered manager following discussion with people, had approached a different GP who was known to one person living at the home. Following a change of GP, people said they found the new GP very understanding of their needs and understood if after booking an appointment when the day came they cancelled it, as they felt unwell.

Support plans contained specific and detailed information about people's past social, personal and criminal histories, used to inform staff when providing appropriate support to people. For example, one person's support plan contained a section entitled, 'Management of Forensic Presentation'. This outlined the person's past behaviours and motivations. There were also assessments of risk factors such as behaviours that challenge, including self-injury, physical and verbal aggression and arson. Each risk factor contained guidance for staff concerning the management of situations, including potential triggers and the measures staff should take to keep the person, other people and themselves safe. For example, the person's trigger to begin self-harming was often a withdrawal from social contact, sleeping on a sofa instead of their bed and hiding their medicines. The support plans contained guidance for staff on how to recognise these risks and put extra support in place to prevent reoccurrence and how people could manage their motivation and

behaviours. All of this leading to people's recovery and ability to move into the community and live a different life.

Staff received training on equality and diversity and our discussions with staff demonstrated a non-judgemental approach to providing care and support. Staff told us they respected people's differences and were certain people who lived at the home felt comfortable talking about matters that were important to them. We observed this to be the case during our observations. Comments from staff included, "We are a small team and we educate each other" and "Staff don't judge – I believe we are receptive to anything." Comments from the staff survey further demonstrated the staff thought about how they had improved their response to meeting people's needs. These were some examples, "The service supports residents to live independently and encourages them to try and take part in new opportunities whilst getting back out within the community." "The service is person centred and the entire staff team are committed to supporting the residents in all aspects of their lives and a caring, safe and effective way." "Person-centred care planning focuses on the needs of the service users and incorporates solutions to problems into daily lives." "The service provides many choices ad helps them with daily tasks and ambitions. We treat all our service users equally." The evidence we saw on the day confirmed these comments were a reality.

Staff respond and go the extra mile to address people's needs in relation to protected equality characteristics. Staff have opportunities for learning, development and reflective practice on equality and diversity, both individually and in teams, which influence how the service is developed. In the office we saw a board titled 'What makes us outstanding', on it were post it notes with comments by staff on what they thought the service did well for people. These have been collated into ideas, strengths, weaknesses and opportunities. These have been shared with staff and the people who use the service to promote the opportunities. For example: staff to encourage people to participate in the life skills they need. Staff to encourage people to shadow and approach the learning of skills slowly, using the mentoring/coaching technique. Encourage service users to try and complete tasks with minimal supervision if possible in line with their own abilities. A second example we saw was 'Reflective Practice'. There were examples of staff having competed a reflective practice record. This meant that staff could develop in practice by identifying strengths and weaknesses. It also enabled staff to recognise areas of development and raise new ideas.

The staff we spoke with were clear about their responsibilities in the management of complaints. The complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. There had been numerous complaints, 22 from one person living at the home. Records demonstrated that each one had been responded to in a professional manner validating the person and the concerns they had. Staff explained that some of the complaints were querying the boundaries that had been put in place with people's agreement. Staff told us people were testing staff to see if they remained constant. The consistency in the responses helped people manage their mental wellbeing to good effect, and was produced in formats to meet people's needs, such as easy read.

Whilst no-one living at the home at the time of the inspection was in receipt of end of life care, people's needs have been considered as part of the end of life care plan and this has taken account of language, communication, ability to understand and capacity when decisions are made. Each person's support plan contained a section entitled, 'Wishes after Death'. This outlined how individuals would like funeral arrangements to be conducted and by whom.

Good

Is the service well-led?

Our findings

People living at the home, health care professionals and staff were complimentary regarding the overall management of the service and the leadership qualities of the registered manager.

A registered manager was in post, they had been at the service since its registration in 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.

We asked staff if they thought the home was well led. One staff member told us, "I'm quite new but everyone has been so friendly and helpful. I think that comes down to the management. I definitely made the right decision coming here." Another staff member said, "The manager and deputy are brilliant. They are so supportive and I can go to them with anything." There were also positive comments in the staff survey for example, "The management make it a lovely place to work. They do an outstanding job and recognition for all their hard work." A heath care professional commented in their survey, "We have excellent communication from the management at Albert Lodge."

Staff told us they feel the manager enables their development and gave us examples. The deputy manager and team leaders now complete weekly medication audits and are responsible for the effectiveness of our medication system. This has led to a positive impact on the home as the service`s delivery and storage of medication has been tailored to be entirely person specific, and has led to initiatives such the self-medicating system.

The registered manager and staff spoke with enthusiasm about the service and displayed an open and transparent approach throughout the inspection. The registered manager was prompt in their actions to provide clearer records around the decision-making process for people who may lack capacity and auditing of accidents and incidents. The registered manager and staff displayed a clear vision and consistent values in relation to the provision of care and the provider's expectations. Evidence was provided to show people were supported to find staff that were well matched and compatible with people living at the home by providing keyworkers and service user interview training to enable people to be part of the recruitment process for their home. It was evident that people living at Albert Lodge were at the 'heart of the service'.

We looked at systems and process in place to assure the quality of the service. We saw the provider reviewed several key areas to monitor performance to maintain standards and drive forward improvement. This included audits in key areas, such as, medicines, finances, care records, health and cleanliness related audits. The home uses a monthly monitoring tool as a planner for work to be completed. The manager told it helps them and the staff to monitor the home and ensure any 'shortfalls' were acted on.

An internal inspection is carried out by the provider's Quality Team in addition to the assistant regional director monthly audits. This audit looks at new key lines of enquiry and a compliance score and priority

actions are given to the service. The manager told us all inspections carried out have come with high scores and on the most recent one, they achieved 94%. Checks are also carried out by the provider at weekends and in the evening to ensure people are being supported appropriately and staffing meets people's needs.

The provider asks people to act as 'experts' to carry out quality audits. They visit each of the provider's services and are used to look at the quality of the service from people's perspective. These reports are presented to the board each month and yearly. The most recent expert audit for Albert Lodge was extremely positive and identified the home as providing outstanding care.
Records were up to date and where required, any shortfalls had been acted on in a timely manner.

Policies and procedures such as safeguarding, whistle blowing and medicines provided guidance to staff regarding expectations and performance; these were subject to review to reflect current legislation and 'best' practice. Staff were supported in their work and information sent after the inspection showed the manager exceeded provider expectations regarding supervisions for staff.

The provider produces a 'quality bulletin', to give feedback to their services on what works well and areas for improvement from all the audits that are carried out. The manager at Albert Lodge has shared this with staff during team meetings to identify areas in the home to improve for example, as 'service user' training.

People using the service, external professionals and staff were actively involved in discussions about the service and were asked to share their views. This was achieved through 'resident meetings', newsletters and the completion of surveys for the annual service review which was last conducted in July 2017. For example; 'service users at Albert Lodge feel that staff care about them.' 'Service Users feel that staff enjoy helping them.' 'Service users are satisfied with the support they receive and their quality of life is good.' 'Service Users feel that that staff do what they say they are going to do.' 'Service users feel safe.' The health professional survey gave the following feedback, which demonstrated how responsive the service was to people's needs. One said, "The service is responsive and communicates well." Another commented, "The service works hard to develop innovative solutions and staff are compassionate in their roles."

We saw evidence that the service worked effectively with other health and social care agencies to achieve better outcomes for people and improve quality and safety. The professionals that we talked with spoke positively about the quality and effectiveness of these relationships. The service had sought feedback from visiting health professionals as part of their annual review.