Care Quality Commission

Canterbury Oast Trust

Ivy Cottage

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Ivy Cottage provides accommodation and personal care for up to five people with a learning disability. At the time of the inspection there were four people living at Ivy Cottage.

The service does not have a registered manager, although the manager had submitted an application to the Care Quality Commission to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager was not available during the inspection and a covering manager had been brought in by the trust to cover their leave arrangements.

Summary of findings

The trust had various systems in place to obtain people's views including meetings and informal discussions. However the trust had not regularly sought the views of people, persons acting on their behalf and staff about their experience of the care and treatment provided.

Records were not easily accessible during the inspection or could not be found. A second visit had to made to view some records.

The service had undergone and was still undergoing a period of major change. A decision had been taken to develop Ivy Cottage into a service for older people who had a learning disability with more complex needs. Two people had moved out and a new person had moved in, which meant that people had very different skills and abilities and support needs. There had also been an almost complete change of the staff team and a change of manager. New staff felt supported, but a minority of staff felt they had not always been supported and had received "mixed messages" from management, who had given different advice and direction. Senior management had recognised that staff worked hard, but there was a lack of leadership to pull the staff together to work more effectively as a team and were working to address this.

People told us they received their medicines when they should. Medicines were managed and administered safely. Two people administered their own medicines. Some changes to medicine records were not signed, dated or witnessed as is good practice.

The service was well maintained. There were systems and checks in place to help ensure that the equipment and premises remained in good condition and working order.

People felt safe living at Ivy Cottage. The service had safeguarding procedures in place, which staff had received training in. Staff demonstrated a good understanding of what constituted abuse and how to report any concerns.

People were protected by robust recruitment procedures. Staff files contained the required information. New staff underwent a thorough induction programme, which including relevant training courses and shadowing experienced staff, until they were competent to work on their own.

People were supported by sufficient numbers of staff, in order to meet their needs and facilitate their chosen activities. Staff vacancies were filled by a bank of staff employed by the trust, so that there was always sufficient. The covering manager had identified that improved planning of staff's time during their shift was required and would benefit people. Staff received supervision and training, but there had been a delay in some refresher training and supervision was not in line with timescales within the provider's supervision policy.

Risks associated with people's health and welfare had been assessed and guidance was in place about how these risks could be minimised. Risk assessments did not restrict people, but were used to promote their independence. There were systems in place to review any accidents and incidents and make relevant improvements, to reduce the risk of further occurrence.

People had opportunities for a range of work and leisure activities that they had chosen. Staff were familiar with people's likes and dislikes and supported people to make their own choices. Staff supported people to be as independent as possible, demonstrated respect and upheld people's dignity.

People said they "liked" the food. They had a variety of meals and adequate food and drink. People were involved in the planning, preparation and cooking of meals.

People were supported to make their own decisions and choices. The manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They were aware of the process, where people lacked the capacity to make their own decisions, to ensure these decisions would be taken in their best interests, decisions such as medical treatment had involved best interest meetings.

People were involved in planning their care and support. Care plans included people's wishes and preferences and skills and abilities. However one person's care plan had not been recently reviewed. They had regular review meetings to discuss their support and aspirations. People's health care needs were monitored; they had access to a variety of healthcare professionals and were support to attend healthcare appointments to maintain good health. Some advice and guidance from a healthcare professional had been slow to be implemented, but this was being addressed.

Summary of findings

People were relaxed in staff's company and staff listened and acted on what they said. People's privacy was respected. People told us they "like" the staff. Staff were kind and caring in their approach and knew people and their support needs.

Staff were able to talk about the provider's vision, mission and values of the trust. There were systems in place to monitor and audit the quality of service provided. Trustees and senior managers carried out visits to the service and staff undertook a variety of regular checks.

People felt comfortable in complaining, but did not have any concerns. Complaints procedures were displayed, but required reviewing and important information adding, to ensure that people were fully aware of how their complaint would be managed.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People received their medicines when they should and management and administration was safe. Two people managed their own medicines safely.

People were supported by sufficient numbers of staff. There was enough staff on duty to meet people's support and activity needs, although better planning of staff's time had been identified as required by the covering manager.

Risks to people's health and welfare had been assessed and measures were in place to keep people safe. Equipment and the premises were maintained and serviced regularly.

Is the service effective?

Requires Improvement

The service was not effective. People received care and support from trained and experienced staff. However there was a delay in staff receiving some refresher training.

Staff used different approaches to encourage people to make their own choices and decisions. Some advice and guidance from a health professional was slow to be implemented.

People liked their meals, they were involved in planning menus and preparing and cooking meals.

Is the service caring?

Good

The service was caring. Staff listened to people and acted on what they said. The atmosphere within the service was relaxed and calm.

People were encouraged to be as independent as possible dependant on their skills and abilities.

People's privacy was respected. People were treated with dignity and respect and staff adopted a kind and caring approach.

Is the service responsive?

Requires Improvement

The service was not always responsive. Each person had a care plan and was involved in review meetings. However one person's pre-admission assessment by the service could not be found and the care plan had not been updated since their move.

People did not have any complaints or concerns. However the complaints procedures displayed within the service required updating, so people understood the correct process.

People had opportunities for a variety of work and leisure activities that they had chosen.

Summary of findings

Is the service well-led?

The service was not well-led. Records could not be found during the inspection and were not well organised.

People, their relatives and care managers had not been asked to complete quality assurance questionnaires since 2012 to provide feedback about the service received.

The service has gone through and continues to go through major changes in all areas. However the changes within Ivy Cottage had not always been well managed. The majority of staff were new and said they felt supported. However a minority of staff did not feel supported. Senior management had recognised there had been a lack of leadership to pull staff together to work effectively as a team and drive improvements and had already taken steps to address this.

Requires Improvement

Ivy Cottage

Detailed findings

Background to this inspection

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

This inspection took place on 19 November 2014 and was unannounced. A pre-arranged return visit to the service was also undertaken on 21 November 2014 to look at records that were not available on the unannounced inspection. The inspection team for both inspections consisted of one inspector who has experience of services for people with learning disabilities.

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 improvement they plan to make. Prior to the inspection we reviewed this information, and we looked at previous inspection reports and one notification that had been received by the Care Quality Commission in relation to an incident between two people, which was reported appropriately.

We spoke with two people who used the service. On the day of the inspection the manager was on leave and a manager who was registered to manager another service within Canterbury Oast Trust (Trust) was covering the service. We spoke with the covering manager and three members of staff.

We observed staff carrying out their duties, communicating and interacting with people. We reviewed people's records and a variety of documents. These included two people's care plans and risk assessments, two staff recruitment file, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys.

After the inspection we contacted three health and social care professionals who had had recent contact with the service and received feedback from two professionals by email and telephone.

We contacted four relatives of people living at Ivy Cottage by telephone to gain their views and feedback on the service provided.

Good

Is the service safe?

Our findings

People told us they felt safe living at Ivy Cottage and relatives told us they felt people were safe as well. People knew who to speak to should they have any concerns and were confident their concerns, if they had them, would be sorted out. During the inspection the atmosphere was relaxed and calm with some interjections of good humour and appropriate banter between people and staff. There was a safeguarding policy in place, which staff referred to for guidance. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedure for reporting any suspicions or allegations. There had been a recent incident that the manager had reported appropriately to the local safeguarding team. Staff had then worked with the safeguarding team putting into practice an action plan that had been agreed to keep people safe and reduce the risk of further incidents.

People told us they received their medicines when they should. Staff had received training in medicine administration. Their knowledge was tested annually with questionnaires. Medicine administration and recording was carried out by staff following a safe procedure. Medication administration records showed that people received their medicines according to the prescriber's instructions.

Two people looked after and administered their own medicines themselves. There were risk assessments in place, to help ensure this was done safely. Two people had recently used medicines purchased at the chemist and staff had obtained authorisation from their doctor, to ensure this was safe to administer with people's other prescribed medicines.

There was an audit trail of medicines arriving at and leaving the service. Medicines arriving into the service were checked against prescribing instructions. Quantities were checked and recorded to ensure there was sufficient for the four week period. Handwritten entries on the medicine administration charts were not signed, dated or witness, to provide clear up to date information about people's medicines. This was also highlighted in the audit carried out by the prescribing pharmacist in September 2014. This is important so there is a clear and up to date record of what changes have taken place, when and by whom. There was an auditing system for when people took their medicines in and out of the service, such as when they visited family. There was a system in place to make sure medicines were returned to the pharmacist when they were no longer required.

All medicines that were managed by staff were stored securely for the protection of people. Temperature checks were taken daily and recorded to ensure the medicines were kept at the correct recommended temperature.

There were records to show that equipment was regularly checked by staff. However on the day of the inspection records to show the premises and any equipment received regular servicing were not available. These were produced on the return visit. Relatives told us that equipment and the premises were well maintained and things were in good working order. Where there were concerns about the premises or equipment, the manager raised an order with the estates department.

Accidents and incidents were reported and clearly recorded. The manager then reviewed these, to help ensure appropriate action was taken to reduce the risk of similar occurrences. Reports were then sent to senior management and the health and safety department for review and monitored for trends and learning. For example, there had been a recent incident and immediate action had been taken with a change to the staffing rota and also staffs working arrangements for the evening shift. After a period of time this had been reviewed by senior management and changes to the rota were reversed as risks had reduced, but the staffs working arrangements remained in place.

Risks associated with people's care and support had been assessed and procedures were in place to keep people safe. For example, where people could display behaviours that might challenge others. Guidelines were in place to help ensure staff took a consistent and safe approach and recognised possible triggers to the behaviour. There had been one incident in recent months and guidelines had been reviewed and updated following this, to help ensure people remained safe. Other risk assessments were in place associated with promoting people's independence. These included travelling independently on public transport, going out to the local community and spending time alone in the service.

People had their needs met by sufficient numbers of staff. People and relatives felt there were sufficient numbers of

Good

Is the service safe?

staff on duty. During the morning shift handover staffing arrangements were discussed by the staff on duty, in order to planned the shift and people's activities for the day. The covering manager had identified that previously although there was enough staff on duty, staffing had not always been planned well, to make the best used of staff's time. For example, arrangements for the day of the inspection were changed by the covering manager, which resulted in the two people who required support each getting one to one support for the whole day. Staff responded when people approached them and were not rushed in their responses. There was a staffing rota, which was based around people's needs and activities. Two people spent the bulk of their days out at activities and did not require staff support at these times. There was a minimum of one staff member on duty during the day, but this could rise to two or three, depending who was present in the service and who required support at activities. One member of staff slept on the premises at night. Part of the action plan agreed with the local safeguarding team had been that there would be two staff on duty between 8pm and 10.30pm, but recently the risk assessment for this had been reviewed and as the risks had reduced, the staffing was reduced to one for this period. Management were keeping this change under review. There was an on-call system covered by management. At the time of the inspection there were three part time vacancies. The service used existing staff or the trust's bank staff to fill any gaps in the rota. There had been a period when an outside agency had had to be used to cover shifts, although this was reducing and the trust was recruiting permanent staff.

People were protected by robust recruitment procedures. Pre-Inspection information showed that three members of staff had been recruited since the last inspection. Recruitment records included all the required information. This included an application form, evidence of a Disclosure and Barring Service (DBS) check having been undertaken, (these checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people), proof of the person's identity and evidence of their conduct in previous employments.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy and "liked" living at Ivy Cottage. Relatives told us they were satisfied with the care and support their family member received.

People chatted and interacted positively with staff. People talked happily about what they were going to do that day, who was on duty or coming on duty, what was on the menu and who was doing what chores. Care plans contained information about how a person communicated although in one case the information was not completely correct. It stated that as well as verbal communication staff should support this person with Makaton (the use of signs and symbols to support speech). However the covering manager told us this was not correct and Makaton was not used.

Staff understood their roles and responsibilities. Staff told us they had completed an induction programme, which included reading, familiarising themselves with people, the building and practices, attending training courses and shadowing an experienced member of staff. All staff completed a common induction standards booklet. This induction booklet is competency based and in line with the recognised government training standards (Skills for Care). Staff had a six month probation period in which their skills and performance in the role were assessed by the manager. The trust had a rolling programme of training in place and staff should have received refresher training at least every three years. This included health and safety, fire safety awareness, emergency first aid, infection control and basic food hygiene. The training records showed there was some delay in staff receiving some refresher training. Some specialist training was provided, such as dementia and it was planned that given the developing needs of people, all staff would undertake this training. Staff felt the training they received was adequate for their role and in order to meet people's needs. Two relatives felt that the staff team was not "established and experienced" within the service. Most of the staff team were new to Ivy Cottage and previously the staff team had all been long serving members of staff within the service.

Staff told us they attended one to one meetings with their manager where their learning and development was discussed. Records showed the frequency was not in line with timescales within the provider's supervision policy. Staff told us they had the opportunity to attend regular staff meetings, which was confirmed by the minutes of the meetings. The majority of staff were new and told us they felt supported, a minority that had worked sometime in the service had not always felt supported. This was due to the lack of stability and many changes that had happened in the service over the last 18 months. For example, changes in the manager, changes in the staff team and changes in people living in the service.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Whilst no one living in the service was subject to a DoLS, we found the manager and staff had received training and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff talked about how people had different skills and abilities in being able to make decisions. They told us about the importance of people being able to express their day to day choices and how they may have to encourage some people to do this. Procedures were in place and had been followed when arranging a 'best interest' meeting for more complex decision making, such as sedation for medical treatment. The covering manager told us that people's relatives and health and social care professionals, such as care managers had been involved in the meetings. Records of the decision making process were not available on the day of the inspection, although some records were available on the return visit. A professional had complimented the staff team on a good example of care. They said the service had adapted to the individual's communication needs, managing the choice making opportunities effectively and in particular the care was collaborative and coordinated.

People had access to adequate food and drink. During the inspection some people were able to help themselves to drinks as they wished and did so. People told us the food was "good" and they were involved in helping to choose the meals. There was a varied menu, which was planned each week. One member of staff talked about how they had recently started to put together a few pictures to aid people's menu choices and planned to extend the range of

Is the service effective?

pictures. The menu was displayed within the kitchen and people knew what was for supper and whose choice it was. Lunch was sandwich or light meal with the main meal being served in the evening when people returned from their activities. On the day of the inspection lunch was a sandwich and crisps. Where a person required a special diet this was catered for. Staff had obtained information and guidance about the diet and records were maintained of the person's food intake. People's weight was monitored monthly and staff talked about how they tried to encourage healthy eating and exercise.

People's health care needs were met. Relatives told us that any health concerns were acted on. One said, "Oh yes, (his health care needs) are met staggeringly well". Good health was promoted and people had an annual health check-up and also their medicines reviewed. People told us that if they were not well they were sure staff would support them to go to the doctor. People had access to a variety of health professionals, such as dentists, community learning disability team, doctors, chiropodist and opticians. During staff handover staff discussed the outcome of a dental appointment and plans were put in place to make sure the dentist's recommendations were followed into practice. Staff also confirmed that arrangements had been made for a follow up appointment for a person following a medical procedure. One health care professional told us that any general advice and guidance was usually adopted and followed, but recently this had been slow to be implemented. For example, looking at the environment in relation to people's deteriorating needs and the use of pictures and signage. During the inspection it was noted that staff had started to use some pictures.

Good

Is the service caring?

Our findings

People told us staff listened to them and acted on what they said. During the inspection people were treated with kindness and staff spoke about people in a caring and respectful way. Staff took different approaches dependant on people's needs, but always took time to listen and interact with people so that they received the support they needed. People were relaxed in the company of the staff, smiling and communicated happily, sometimes with good humour. Relatives were complimentary about the staff and thought staff were "very caring". One relative said that the bank staff used were also "of a high standard". Another relative said, "Can't fault anybody".

People were involved in the planning of their care and support. Where appropriate people had signed their care plans as a sign of their agreement with the contents and people had also attended their care review meetings. People were able to make choices about their care and support, such as what activities or work programmes they did, when they got up or had a shower. Staff told us that some people were quite independent and always made their own choices and then how they encouraged others by offering a choice of two items, such as food.

People's care plans had details about their personal histories. This helped staff to understand people and what was important to them. Staff talked about how they had got to know people and their histories by talking to them and their families.

People were able to choose where they spent their time. For example, most people were up and about when the inspector arrived and in and out of their rooms, although one person chose to rise a bit later and this was respected by staff. One person was watching television or listening to music in the lounge and another spent time between the lounge and their room. People chose to eat their lunch in the lounge/diner.

People's independence was promoted. People talked about choosing meals they liked to have on the menus and helping to prepare and cook meals. People sat down each week with staff to decide the menus and the choice of the evening meal rotated. People had agreed if they chose the evening meal, then that evening they would help prepare and cook the meal. Then other people would lay the tables or wash and dry up. Some people were able to make their own drinks. Staff had supported some people to do travel training and they were able to use public transport, such as buses and trains independently. Each person had a house day and people told us that during this day they cleaned their rooms and did their laundry. People were also involved in cleaning communal rooms as well. For some people this was independently and others had staff support depending on their skills and abilities. Two people were quite independent and staff were working with them with a view to moving onto independent living. Since the last inspection two other people had been supported to move into independent living accommodation.

People's family and friends were able to visit at any time. When the inspector first arrived a person's friend had popped in to speak to them before they both went off to their day's activity. People had their privacy respected. One person told us they did not have a key to their room, but that this space was treated as private and they knew their possession were safe in there. Staff knocked on doors and asked if they could come in before entering. Relatives told us that people's privacy and dignity was always respected. Health care professionals told us that people were treated with dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

People were involved in planning their care and had review meetings to discuss their goals and any concerns. Staff told us that one person had asked during their review for staff support to lose weight. Staff had helped facilitate this by supporting the person to join the gym and go swimming. Relatives told us they attended six monthly review meetings. Staff told us at reviews people, their relatives and care manager usually completed a quality assurance survey to give their feedback about the service provided. However there was no evidence of any surveys completed since 2012, which meant people, their relatives and social workers had not had any formal opportunities to feedback their experiences of the service provided or any concerns to the trust for at least two years.

One person had moved into the service since the last inspection from another service owned by the trust. This was because it was felt their needs could be better met here. The covering manager told us that the manager would have carried out a pre-admission assessment. However there was no evidence of this held on the person's file. Records showed that the person was able to 'test drive' the service by spending time, such as for an evening and a meal, getting to know people and staff. On one visit they were accompanied by their social worker. The person transferred and brought a copy of their care plan with them. In addition a meeting was arranged between the previous staff team and the new staff team for a proper handover about care and support needs. However the care plan that had transferred with the person, who had moved in, had not been reviewed or updated since that date (September 2014). Although the personal care detail did reflect the person's current needs, there was some other information relating to the environment, which was no longer current.

People had signed their care plans, confirming their care plan was about them and how they wanted to be supported. Care plans contained details of people's choices and preferences, such as food and drink. Care plans contained information in relation to people's skills, abilities and support needs regarding areas, such as bathing or showering, hair care, nail care, communication and attending health care appointments. Most care plans were regularly reviewed and reflected people's assessed needs. People's care plans had details of their life history and family life. This helped enable staff to understand people and what was important to them.

People participated in monthly residents meetings that were minuted by them. They had the opportunity to voice their opinions about their care and support and any concerns they may have. People said when they raised any issues they were dealt with. Special trips and days out were also discussed. One person had raised that they wanted to catch the bus to one of their work placements, so they were now taken to a bus stop and caught the bus from there. People had decided they wanted to sell their pool table and wanted staff to support them to make posters to advertise this and this had been done. One person had wanted to meet with the trusts recruitment officer who arranged work placements for people and this had been arranged.

People had a programme of leisure and work based activities in place, which they had chosen, to help ensure they were not socially isolated. Some people had fuller programmes than others and this was based on people's skills and abilities and also their choices. Work based activities included working at a garden centre, restaurants, computers, craft, gardening, woodwork and horticulture. Leisure activities included swimming, gym, meeting friends, church, shopping, television and music. During the inspection people were out at various activities. One person went shopping and when they came back they pleased themselves how they spent their time. Another person spent the morning in, and then went out to get their hair cut.

People told us they would speak to a staff member if they were unhappy. They felt staff would sort out any problems they had. There were different types of complaints procedures displayed within the service. There was a resident's complaint procedure and then two visitors' complaints procedures. All required updating as they did not refer to the Local Government Ombudsman that people could direct their complaint to if they were unhappy about the way it had been investigated. There had been no complaints received by the service in the last 12 months. During the inspection the office door was always open when occupied and people could freely go in and speak with the covering manager as they wanted. Staff told us that any concerns or complaints would be taken seriously

Requires Improvement

Is the service responsive?

and used to learn and improve the service. Relatives told us they felt comfortable in raising any concerns that might arise. They told us when they had raised concerns these had been listened to, taken seriously and acted on.

Requires Improvement

Is the service well-led?

Our findings

Staff told us people, their relatives and social workers should all complete quality assurance questionnaires to give feedback about the services provided. However there were no completed questionnaires on file since 2012, which meant people and their relatives had reduced opportunities to feedback about the service and drive improvements.

This was a breach of Regulation 10(1)(2)(e) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records were stored securely. Some records were not readily available during the inspection and a return visit was made to examine those records that could be found. One person's pre-admission assessment could not be found. One care plan was not up to date and it was not easy to ascertain which information was the most current. This lack of organisation of records impacted on the service making progress on identified shortfalls very slow. For example, the report for the medication audit that had been carried out in September 2014 could not be found. Therefore the covering manager had to obtain a copy of the report from the pharmacist during the inspection and was the required to ascertain for themselves if any action had been taken against the identified shortfalls. One shortfall that was highlighted at the previous inspection was recording the amounts of medicine handed over to people, as one of the steps to reduce the risks when people were self-administering their own medicines. Staff told us this had been implemented following the inspection, but was no longer in place and nobody knew why. The covering manager agreed this should be in place and agreed to address this.

This was a breach of Regulation 20(1)(a)(b)(ii)(2)(a) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

Over the last 18 months the service had and was still undergoing a period of major change. Two people have moved to independent living accommodation. Another two people were working with staff and management with a view to also moving into independent living accommodation. The trust has made a decision that the future of Ivy Cottage would be developed into a service for elderly people with a learning disability and more complex needs. Therefore at the time of the inspection the service had a mix of people with very different skills and support needs. Apart from one member of staff, the team had completely also changed. Since the last inspection the previous registered manager who had been fairly new had left and a new manager had joined Ivy Cottage. There had been a period without a manager where cover arrangements were put in place. The majority of staff felt supported. However one staff member said, "It's been uncertainty and unsettledness". Relatives also felt this had impacted on the service and would welcome a period of better continuity. Senior management had recognised that not all the changes had been well managed and there had been a lack of leadership to pull staff together to work effectively as a team and drive improvements and were already taking steps to address this.

The manager was on leave during the period of the inspection so we were unable to speak with them. They had submitted their application to registered with the Commission in August 2014. The manager was responsible for two services and worked 18.5 hours in each service. The manager was supported in Ivy Cottage by an assistant manager who worked three days a week. In Pre-Inspection information the manager told us they had an open door policy. The manager attended regular managers meetings, to keep managers up to date with changing guidance and legislation and drive improvements. Relatives told us they felt comfortable in approaching the manager. Comments about the manager included, "She is absolutely fantastic, a breath of fresh air, caring, knowledgeable and willing to listen". "She is friendly and helpful" and "Very good".

One health care professional felt that some recent advice and guidance had been very slow to be implemented. They felt through a lack of management to allocate the task to an individual staff member, none of the staff team had taken responsibility and progress had not been made. They had taken this up with senior management and action had already been taken to introduce the use of pictures within the service.

The manager had recognised some of the key challenges ahead for the service and these were detailed in the Pre-Inspection information, together with action they intended to take to manage these.

Staff said they understood their role and responsibilities. They had regular team meetings where they could raise any

Requires Improvement

Is the service well-led?

concerns. Staff were kept informed about the service, people's changing needs and any risks or concerns. Staff told us they used the daily handover to keep up to date, discussed things and agreed a way forward.

Trustees and senior managers visited the service to check on the quality of care provided. People and staff told us that these visitors were approachable and made time to speak with them and listen to what they had to say. The Trustees had visited the service in October 2014 and no concerns were identified, although some areas for improvement were discussed. Reports of senior managers' quality monitoring visits were not available on the first day of the inspection to view. However on the second day we saw that these visits had highlighted shortfalls and some action had been taken to address them.

All relatives felt the service was well-led. One commented, "They listen to us".

The trust had a vision, mission and set of values although these were not displayed within the service on the first day of the inspection. Staff confirmed that the chief executive and senior management held a communication meeting twice a year that all staff could attend. The vision, mission and values were on the agenda and discussed. One staff member told us that these included supporting people to be as independent as possible and upholding people's dignity.

The trust organised service user panel meetings where the business and future of the trust was discussed. Each service, including Ivy Cottage, had a representative on the panel, which was a person that used the service. People had the opportunity here to shape things that were happening within the trust. For example, people had recently been involved in reviewing the care planning paperwork to make it more service user friendly. People could access the trust's website to see what had been discussed.

During 2014 the trust set up a group for siblings of people living within the trust. This was for support, to share experiences, to learn from each other and to build a network for membership. It was planned that the group would meet twice a year.

The trust produced a regular newsletter and "in-touch" magazine to keep people and staff informed about news and events that were happening within the trust. For example, the local authority retendering process and CQC's new inspection methodology and service ratings.

During 2014 the trust was awarded a National Care Employer of the year award from the Great British Care Awards scheme.

Staff had access to policies and procedures via the trusts computer system. These were reviewed and kept up to date by the trusts policy group.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider has not regularly sought the views of services users, persons acting on their behalf and staff about their experience of the care and treatment provided.** **Regulation 10(1)(2)(e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person must ensure that service users are protected against the risk of unsafe or inappropriate care arising from a lack of proper information.** **Regulation 20(1)(a)(b)(ii)(2)(a)**