Care Management Group Limited

Care Management Group - 4 Vallance Gardens

Inspection report

4 Vallance Gardens
Hove
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Ratings

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

Overall summary

We completed an unannounced inspection of this service on the 9 and 10 February 2015. 4 Vallance Gardens provides support for up to ten people with learning disabilities, physical disabilities, communication and sensory impairments and complex health needs, including epilepsy. At the time of the inspection, seven people were living at the service. The age range of people varied between 52 – 86 years old.

Accommodation is close to the town centre of Hove. It was arranged over two floors with a communal lounge, dining area, large kitchen and garden.

The cleanliness of some of areas of the home such as the carpets and cleaning of walls and woodwork had not been maintained to a high enough standard. People were exposed to an environment where cleanliness was not maintained across all areas, increasing risk from poor hygiene maintenance.

Summary of findings

Audits of cleaning had not identified the failure to complete tasks relating to cleanliness and infection control.

People's medicines were stored safely and were administered on time. Guidance for the use of 'as required' (PRN) medicines were not available. We have made a recommendation about the management of some medicines.

There was a registered manager at the service on the day of our inspection. 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 registered manager explained that the service tried to meet the needs of older adults with complex needs. People were well cared for and appeared happy with the support they received. The relative or representative of one person told us, "It's a good place for people." A health care professional told us, "It is apparent that the staff member has a good relationship with the resident they have known for a number of years. The resident appeared well cared for and dressed in attractive clothing of their own choice."

People received focussed, person centred support. Their needs had been assessed and support plans devised and implemented. The plans and risk assessments provided staff with the guidance they needed to for safe, effective and responsive support. Staff supported people with positivity and kindness. It was clear they appreciated the importance of people's personal histories and had built an enduring professional relationship with them.

People went out and about, shopping and to places of importance to them. There were good opportunities for taking part in social activities. Support staff ensured people had lots of engagement and stimulation both in and outside the service.

People were provided with a choice of healthy food and drink ensuring their nutritional needs were met.

People's relatives, representatives and professionals alike spoke highly of the service provided, the staff and the manager. One social care professional told us, "I found the manager had an excellent grasp of the needs of the person I was completing a review for." Staff understood the principles of the provider and how these permeated all areas of the service. This was reflected in the full lives people were able to lead. The manager was committed to the ongoing improvement of the service.

People's relatives told us they felt the service was sufficiently staffed. Practice was reviewed with regard to safe ways of working and ensured people were not placed at risk.

Staff had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments were recorded in line with best practice guidelines and staff were aware of who was subject to a DoLS authorisation and what it meant for the individual.

There were procedures in place to assess the standards of support. Feedback was sought from people or their visiting relatives. Incident and accidents were consistently recorded and reviewed for emerging trends or patterns.

People's privacy and dignity was upheld. Staff understood how to recognise abuse and were clear on how to raise a safeguarding alert. They spoke highly of the training opportunities provided and commented they felt supported and valued.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement

4 Vallance Gardens was not consistently safe. Arrangements for keeping the service clean and for adequate maintenance to ensure people were protected from acquiring an infection were not in place across all areas of the service.

People received their medicines on time. Clear guidance and risk assessments were not always available on when PRN medicine should be administered but staff demonstrated knowledge of people's needs and when it may be required to be given.

Staff understood what adult abuse looked like and were clear on how to raise a safeguarding alert.

There were risk assessments that recorded the measures taken to keep people safe.

Is the service effective?

Good

4 Vallance Gardens was effective. Staff had received training to provide effective care and support to people.

Mental Capacity Assessments were completed in line with best practice guidelines. Staff understood Deprivation of Liberty Safeguards (DoLS) and what that meant for individuals.

People saw health and social care professionals, when needed. People received the support they needed for their complex health needs.

Is the service caring?

Good

4 Vallance Gardens was caring. People's relatives and professionals spoke highly of the service.

Support was provided with positivity and kindness. People were consulted and encouraged by attentive staff to make choices to make choices within the range of their interest and needs.

Staff spoke with care and passion about the people they supported and it was clear staff had spent time getting to know people's likes and dislikes. People were supported to dress in accordance with their personalities and lifestyle. Support staff were observed speaking about the personal care needs of people sensitively and discretely.

Is the service responsive?

Good

4 Vallance Gardens was responsive. Plans were detailed and had enough information to provide staff with the guidance they need to provide personalised support.

Summary of findings

People's relatives spoke highly of the opportunities for social engagement and stimulation. There was a full programme of meaningful activities and stimulation for people.

There was a complaints procedure in place and staff told us they would raise concerns.

Is the service well-led?

Requires improvement

4 Vallance Gardens was not consistently well led. Audits of cleaning had not identified the need to complete monthly tasks relating to cleanliness and infection control.

People's relatives, representatives and health care professionals made positive comments about the management of the home and staff spoke highly of the manager. The manager was open and responsive to the areas of concern identified.

Staff were clear on the visions and values of the service. They expressed a strong commitment to delivering positive, person centred support.

Care Management Group - 4 Vallance Gardens

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. The 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.

The inspection was carried out over two days on 9 & 10 February 2015 and was unannounced. It was carried out by two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted selected stakeholders including two health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided.

During the inspection we spent time with all the people who lived at the service. We also spoke with three relatives or friends of people who lived in the home. We spoke with the registered manager, the deputy manager and four support staff.

We observed the support people received. We spent time in the lounge, kitchen and dining area and we took time to observe how people and staff interacted. Because people had complex learning disabilities that restricted their spoken language we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at three sets of personal records. They included individual support plans, risk assessments and health records. We examined other records including three staff files, quality monitoring, records of medicine administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 9 January 2014 and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

The relative of one person told us, "Everyone is happy there and [my relative] is safe." People were comfortable in the company of support staff and they respected people's autonomy and freedom. However, we found areas of practice which were not consistently safe.

There were not robust arrangements in place for keeping the service clean and hygienic to ensure people were protected from acquiring an infection. The cleanliness of some of areas, such as the carpets and cleaning of walls and woodwork had not been maintained to a high enough standard to prevent risks to people. In one room we found water leaking from a hand basin pipe which had led to a significant amount of liquid on the person's carpet so that it was wet to the touch. It could not be established how long the leak had been active. In the same room we saw a clear gap in the panel of an external door so that daylight could be seen through it. This had not been identified in any previous maintenance audit. In several other rooms we saw stained carpets, cobwebs, dust and mould, particularly on windows and their frames. These were in areas that were on cleaning rotas but that had been missed. In one room we saw a section of carpet approximately 1 foot by 1 1/2 foot entirely missing from the floor and the edges around it frayed. This caused a potential trip hazard for people, staff and visitors to the house. We were told by the registered manager that the carpets last received a deep clean eighteen months previously and that they had logged with the provider a request for different flooring materials for areas of the service, including some bedrooms. They acknowledged, "The carpets are dreadful." On the second day of our inspection we saw cleaning firms invited in to the service to quote for the work of cleaning the carpets.

The registered person had not protected people against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine Administration Records (MAR) charts confirmed some people were prescribed medicine on an 'as required' (PRN) basis. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. For some people, medicines can be prescribed to, for example, relieve behavioural and psychological symptoms and manage behaviour. Very few people were prescribed PRN medicine to manage behaviour and MAR charts confirmed these medicines were rarely administered. However, there was not always information available to guide staff about when people may need their medicine and therefore benefit from their PRN medication. Consequently, it was difficult for us to know that people always received their medicines effectively. For example, directions for some medicines stated that one or two tablets could be taken but there were no instructions to explain in what circumstances they should be administered. This meant that people may not have had their needs identified and managed appropriately or safely in all cases. However, when we spoke to staff about the medicines people received they were knowledgeable and able to describe the circumstances when PRN may be required to be given.

Medicines were recorded, stored and ordered appropriately. The stock levels of medicines were checked on a regular basis and medicines, other than those noted above, were administered in line with good practice guidelines.

Staff respected and celebrated people's individuality, autonomy and freedom. A person was seen going outside for cigarettes and people were seen regularly coming and going from the service with staff support. Risk assessments recorded and reflected the good practice undertaken by staff. For example, for all the people living with complex health and social care needs there was a strong desire to support them to go out and about in the community. A risk assessment was devised to enable each person to go out to local cafes, shops and other areas of importance to them. The level of detail drilled down to, for example, consideration of weather and if the person was wearing appropriate clothing and footwear. The measures kept people safe but also respected their autonomy and were clearly documented in the risk assessment.

Some people could exhibit behaviour which may challenge others, such as anxiety and occasionally, physically challenging behaviour. We looked at staff's management of behaviour that could challenge and the risk assessments in place to provide guidance and support. Staff understood how to spot and use distraction techniques to try to avoid

Requires improvement

Is the service safe?

potentially difficult situations. They responded positively to behaviour that could challenge. One staff member told us, "We have to be aware of our approach when trying to support the person. But we know people really well and we know what works for them." For example, behaviour guidance for staff explained a person's known behaviours and what they were interpreted as trying to communicate. Responses to the individual behaviours were recorded which were found to minimise the incidence and impact of unwanted behaviours. Risk assessments identified the risk and incorporated the protective measures required by staff to keep the person and other people safe.

Staff understood what constituted adult abuse and could clearly identify various forms of abuse. One member of staff told us, "Safeguarding training was useful for me as it was practically based in its discussion of examples, which helped." Staff understood that abuse was not tolerated and should always be reported. We were confident from what we saw and heard that any concerns of abuse or neglect would be reported to the manager. Documentation confirmed the manager was responsive to any concern of abuse and neglect and raised safeguarding alerts in line with local protocol. We asked staff who they would report their concerns to if the manager was away. One staff member told us, "I would contact the regional manager and if it was needed, I would contact social services." Staff were aware of their responsibility to raise a safeguarding alert with the Local Authority if it was required. The manager addressed the issue of safeguarding and whistle blowing as an on-going topic within supervision and staff meetings. The manager demonstrated that they understood that safeguarding alerts should be raised in a timely manner and demonstrated knowledge of the process.

People's relatives and representatives and staff we spoke with felt the home was sufficiently staffed. One person told us, "There's a lot of staff but then, they're needed. There's something, a board, in the hall that shows who's on today and who's on tonight." A team of four support staff were working during our visits. The manager and newly appointed deputy were available throughout the week and provided on-call support at weekends.

Needs assessments indicted the required support people needed from staff. The staff rota showed the service had the number of staff on duty required to safely meet people's needs. We discussed staffing levels with staff who gave different views of present staffing arrangements, one person said, "Staffing levels are good", while another thought , We've had mornings with just 2 or 3 staff, it's back breaking and people can miss out on community access. Can't fault people's needs being met, it's the staff who aren't looked after. The manager said, "We had a period of staff turnover. People left Brighton and Hove, which can be a transient town anyway, while others went on to develop their careers, for example to go to begin their nurse training. Some of those that have left as permanent staff have come back as bank staff. Now I think we are much more settled as a team." People were safe because there were sufficient staff available to meet support needs. Additional staff were available to respond to any unplanned events that might occur. For example, staff supported a person in hospital on a 1:1 basis for a sustained period of time. Staff absorbed the resource implications of the staffing commitment by working extra shifts within guidelines set out and thereby ensured the safety of people.

Recruitment procedures were in place to ensure that only suitable staff were employed. Records showed staff had completed an application form and interview and the provider had obtained written references from previous employers. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff.

We recommend that The registered person considers the National Institute for Health and Care Excellence (NICE) national guidance for best practice on developing and reviewing policies for safe and effective use of medicines

Good

Is the service effective?

Our findings

Relatives and professionals spoke highly of the support staff and felt they received effective care. One visiting relative told us, "I've got no concerns about the staff." As well as the positive feedback, we also saw practice which was consistently effective. People responded to staff positively when they were supporting them with their daily routines.

Support plans were put together using words, pictures and symbols. Consideration was given to how people had the content of their support plans shared with them to make the process meaningful and to seek to gain that person's agreement. They contained clear information about how a person communicated and this was reflected in what we saw during the inspection. Staff deployed a range of strategies to seek to communicate consistently and effectively. They not only acted on people's verbal communication such as words but also their facial expression, noises and gestures.

People's health and well-being was monitored on a daily basis. Health and social care professionals from a range of disciplines visited the home on a regular basis and documentation confirmed staff regularly liaised with GPs, physiotherapists, nurses based in the community and speech and language therapists. Relatives told us health concerns were acted on and they were told about any changes of the health. They talked about the complex medical conditions their family members had and how well managed this was.

Staff recognised how people's healthcare needs may change and how they may not always be able to communicate when they are feeling unwell. For example, we saw a speech and language therapy referral was made following keyworkers noting a change in the presentation of a person. One staff member told us, "I think we are able to see the signs when a person is unwell. For example, as well as the physical symptoms we can spot the changes in behaviour, just how they are. That comes from working with people so closely." They recorded when advice was sought or when a referral was made. This included to any hospital or GP. They recorded the outcome from appointments along with feedback from healthcare professionals.

People were having input from a variety of health professionals. For example, the community learning disability team monitored a person's deteriorating physical and mental health related to their advancing age. Health and social care professionals told us that staff worked with them and any advice and guidance they provided was adopted by staff and incorporated into the support plans. They felt staff addressed any health care needs as they arose.

We discussed the requirements of the Mental Capacity Act 2005 (MCA) with the registered manager and staff. The MCA provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The legislation states it should be assumed that an adult has full capacity to make a decision for themselves unless it can be shown that they lack capacity to affect their decision making at a specific time and regarding a specific decision. Only at this point would there be an indication for an assessment. The registered manager and staff we spoke with were clear in their understanding of the requirements of the MCA and were able to demonstrate this in relation to a best interest decision to pursue a course of treatment.

The registered manager considered the impact of any restrictions put in place for people that might need to be authorised under the Deprivation of Liberty Safeguards (DoLS). The legislation regarding DoLS is part of the Mental Capacity Act 2005 (MCA) and provides a process by which a provider must seek authorisation to restrict a person for the purposes of care and treatment. The registered manager was aware of the changes to the interpretation of the DoLS as a result of court rulings. Where people did not have capacity to make decisions in relation to where they lived the manager had correctly identified that the controls in place at the service represented a deprivation of liberty. The service had made appropriate applications and three people were currently subject to authorisation under the DoLS.

Staff understood their roles and responsibilities. The provider ensured staff completed the training they needed to work with people effectively. New staff were required to complete an induction programme that included; reading support files and organisational policies and procedures,

Good

Is the service effective?

orientation within the service, shadowing experienced staff and attending and completing training courses. All staff had a probationary period to assess their skills and performance in the role.

Staff were up to date with training the provider considered mandatory. This included safeguarding adults, fire safety, medicines management and food hygiene. Specialist training was provided, such as training on epilepsy and the effects of old age and dementia for people with a learning disability. There was training in the process of enteral feeding, the delivery of a nutritionally complete food, directly into the stomach and staff were assessed in their competency. Staff felt the training they received helped them fulfil the expectations of their role and meet people's needs. Staff understood and appreciated the need for targeted training, for example in dementia. They explained how training they had completed, enabled them to think about and develop the use of communication aids. Staff told us they attended one to one meetings with their manager where their learning and development was discussed.

Staff acknowledged that it was difficult but not impossible for the majority of people to communicate what they wanted to eat. We were told, "We pick up on the prompts they give us. For those able to feed themselves food can be left or just pushed around a plate. For others that need the support with feeding, they turn away or not show their usual interest in eating a meal." In these sometimes small but nonetheless significant ways, people were involved in making their own decisions about the food they ate. During mealtimes we saw this reflected in sensitive and responsive staff practice. Staff noted and responded to the wishes and signals people gave about their enjoyment of their meal.

One relative told us that the food "Always looks very nice. They have a good diet". There was a varied menu, which was planned and changed on a four weekly basis and reflected the season. People were involved in planning the menu; pictures were used to encourage a varied and healthy diet. Staff also added their in depth knowledge of people's likes and dislikes where they were unable to make a choice.

A dining area of a table and chairs was incorporated into the communal space in the service and was laid out so that it was accessible to all. Thought was given to how to effectively include people in the activities associated with preparing food in the kitchen. One person was seen being supported into the kitchen while homemade soup was being prepared. Though the person could not directly contribute physically, they actively observed and got stimulation from the social interaction surrounding them.

Many people followed specialist diets based on their particular healthcare needs. People's weight was monitored against the special diets they followed. Staff explained people's food and fluid intake was monitored to make sure they did not become malnourished or dehydrated. Health professionals had been involved in assessments of people's nutritional needs. Recommendations they had made had been followed through into practice. We spoke with a visiting health professional who said, "The home is really positive. They have been following the guidelines that I worked out with them twelve months ago." Aids and adapted equipment was used to help encourage people's independence when eating and drinking, such as plate guards and special spoons.

Good

Is the service caring?

Our findings

People spoke highly of the service. The relative or representative of one person told us, "It's a good place for people." A health care professional told us, "It is apparent that the staff member has a good relationship with the resident they have known for a number of years. The resident appeared well cared for and dressed in attractive clothing of their own choice." As well as the positive feedback about the support provided, we observed practice which was caring and sensitive.

The atmosphere in the service was relaxed and friendly. A warm, cooperative and mutually supportive approach was taken by staff to the support needs of people. The large communal lounge area was the centre of much interaction and activity during our visit. As well as a television and music system it also had a fish tank which aided relaxation. The lounge and dining area was an important central space and provided a stimulating and friendly environment for people to relax in.

There was a strong bond and rapport between people and staff which was underpinned by the staff's knowledge and understanding of people's needs. Where people had difficulty communicating verbally staff recognised facial expressions, gestures and sounds as well as changes in demeanour. This helped them interpret how each person felt and whether they were happy or distressed for any reason. Staff maintained a steady stream of appropriate, warm interactions with people, some of whom were not always able to respond in turn. The use of language, verbal and non-verbal, was considered rightly as a key element of good quality support and care and was significant for how it impacted upon the person's self-worth.

All support planning and risk management documents were produced in easy read formats to make the information easier for people to understand. Staff were able to tell us how each person communicated their needs and we saw staff used a variety of methods to communicate with people. We heard clear, warm and positive language deployed effectively. Staff used a form of Makaton, which is a type of sign language, pictures and objects of reference to aid communication.

People's dignity was considered and protected by staff. Staff always knocked before entering bedrooms and made sure that doors and curtains were closed when helping them with support, including personal care. One staff member told us, "Peoples own space is respected and we always knock before entering a person's bedroom." Support staff were observed speaking about the personal care needs of people sensitively and discretely. People were supported to dress in accordance with their personalities and lifestyle.

Staff followed the principals of privacy. There were arrangements in place to store people's support records, which included confidential information and medical histories. The room used to store records was secure. Personal and private information was not left unattended.

The provider respected and met people's cultural care needs. People's support plans included sections on How to Meet My Cultural Needs. This covered all aspects of the person's life including their dietary and spiritual needs. For example, we saw that one person was a member of a minority faith. The staff responded to their needs in ways as diverse as attending religious services and the impact on their diet.

People's relatives and representatives told us they felt listened to and supported by staff. They felt their family members were well cared for. One relative told us, "The staff are ever so kind and always look after people." People were involved in the decision making process about their support, for example through involvement in the keyworker process where ideas for future opportunities and plans were discussed. Issues whereby a person with a severe learning disability may not be able to follow or positively contribute to a discussion were considered. The possible negative impact of a person, for example, attending a review and becoming bored and distressed by the meeting were shared with us and consideration was made of the individual at each stage. Relatives were provided with opportunities to read their loved one's plan and make any further remarks or comments. Support plans had been signed by people or their representatives/relative to show they agreed with them. Relatives said they were always informed about their loved one's progress and kept informed of any changes or updates.

Five people had moved to the service at the same time from a long stay hospital where they had spent many years living. The advancing age of some of the people and the social isolation that sometimes occurred as a result of the institutionalised approach to care at hospital meant that some people had found it difficult to keep in touch with

Good

Is the service caring?

their family members. Support networks for each person outside of people paid to support them was recorded. Staff encouraged people to access support networks outside the service. We saw that attempts were being made to obtain an advocate for a person who had moved to the service. For those people who had continued to maintain family networks we heard that were able to visit at any time and were always made welcome. People could see their visitors in the communal lounge or in their own bedroom. One visiting relative told us they could visit at any time and were always made to feel welcome.

Good

Is the service responsive?

Our findings

A relative said they felt fully involved in the support of their family member. They told us that they visited regularly and were updated with any changes or issues that might affect support. People's support plans clearly identified their needs and reflected their individual preferences for all aspects of daily living. Support documentation contained detailed personal profiles and family history. One staff member told us, "In order to understand the background of a person the support plans were a helpful starting point."

Staff demonstrated good knowledge of people and used strategies to meet people's sometimes complex care and support needs. For example, staff were able to provide a detailed answer to the causes associated with a particular behaviour and responses that were required to meet it. The explanations for a particular approach to supporting an individual was reflected in the support plans. Support plans demonstrated assessments of people's individual needs and identified how these could be met. Areas included mobility, emotional needs and all aspects of personal care appropriate for that individual. People's choices and welfare were responded to positively. For example, everyday sensory experiences were thought about and structured in a way so that specific skills were encouraged and participation was maximised. This was done by breaking down the task into small steps; each step, whether it was sight, taste, smell or feel was offered with choices to encourage and supporting them to engage in the activity. This included providing preferred activities and promoting awareness of the environment.

Opportunities were available for people to take part in a wide range of daily activities. These included activities around the home for example, in the kitchen, with arts and crafts or out in the garden. People were given choices about the activities on offer and were asked if they wanted to participate in them. Although people weren't always able to tell us they enjoyed activities on offer we saw they engaged with activities with enthusiasm and joy. Activities were based on people's interests and lifestyles. For example, an older person chose activities based in the home around their preferred interests. While, for a younger and physically more active person their interests took them out and about more frequently with staff 1:1 support.

People were supported to become involved in other activities that were available within the local community. There were opportunities for regular visits out into the local and wider community. These trips were chosen by and for people according to their interests. Staff actively worked with people, each other and with the manager around the planning of these activities. One member of staff told us, "There are some shops just at the end of this road and [a resident] knows all the shop keepers there. Everybody there greets him by name. He's a larger than life character."

The week before our visit a funeral had been held following the death of a cherished and long term resident. We heard how staff had supported the person in hospital. Consideration was given to meeting the feelings of loss felt by all people and staff. Pictures of all the people living at the service were prominently displayed and among them were the images of the deceased. People and staff were given space to discuss in depth how they were feeling. For people who had difficulty expressing their thoughts, their behaviours and actions were considered against what had happened. For example, staff said a person might not be able to say that they missed a departed person but their actions might indicate a reaction to loss or change. The manager said, "Changes in the service can present challenges that we need to reflect on, these discussions help inform our practice."

Records showed processes were in place to capture comments and complaints though none had been received in the period to our inspection. Procedures were present to manage and respond appropriately to any changes that were required following receipt of a complaint. Staff told us they would raise concerns. For example, based on their knowledge, if they saw a change in the presentation of a person they would take their concerns to the registered manager. The procedure for raising and investigating complaints was displayed in easy read format in around the service. A relative told us, "If I was unhappy I would talk to the manager."

Because of the additional complex needs of people, the staff had thought about and implemented creative ways of involving and capturing the views of people. Meetings were held around themes to capture and hold the interest of people. For example, an India theme ran through one meeting which stretched out for an afternoon and evening. As well as discussion around an agenda people also shared a meal based on the theme. Minutes were recorded and action points on activities were seen to be followed up. For example, one person had the opportunity to take the bus

Good

Is the service responsive?

to the Royal Pavilion for the first time. Another person went shopping for new clothes and choice was based on what staff, who knew the person well, noted what they liked to look at in their wardrobe and what they were comfortable wearing. The provider hosted 'Service User' conferences to which delegates from all of their other homes were invited to attend. The minutes from these meetings were available in easy read format for people to follow. For people who were unable to communicate verbally the service had also sought feedback from relatives and other significant people to discuss how the individual's needs were being met. The registered manager said, "The feedback from others with an outside view is valued by us and I have to say, usually positive."

Requires improvement

Is the service well-led?

Our findings

People's relatives, representatives and healthcare professionals spoke highly of the service provided and staff expressed confidence in the manager. One member of staff told us, "The manager is brilliant. She keeps us informed and understands the issues. They facilitate things for staff". A professional told us, "I found the manager had an excellent grasp of the needs of the person I was completing a review for." Despite people's praise we found areas which were not consistently well-led.

Systems were in place to monitor and analyse the quality of the service provided. These included audits and quality assurance checklists. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits identify what the service does well and highlight shortfalls and areas for improvement. They help drive improvement and promote better outcomes for people who live at the service. Despite having the mechanisms in place to review the quality of the service provided, the manager was not consistently completing them. For example, audits of cleaning had not identified the failure to complete monthly tasks relating to cleanliness and infection control. Two audit processes were found to have not identified issues impacting on the quality of service. They were the cleaning audit and the audit covering PRN medicines. The registered manager accepted the oversights within the audit process in these two areas and was in the process of immediately addressing this.

There was a system in place for recording accidents and incidents. We reviewed a sample of these and found recordings included the nature of the incident or accident, details of what happened and any injuries sustained. The manager monitored and analysed incidents and accidents to look for any emerging trends or themes. Where actions arising had been identified, recording demonstrated where it was followed up and implemented. For example, one person had fallen from a wheelchair and the action from the incident and accident log identified that an occupational therapist referral was necessary to provide additional professional advice and help prevent a reoccurrence. We were able to see actions had been taken and how this on-going risk to this person would be reduced.

Systems were in place to seek the views of people, their relatives or representatives. Satisfaction surveys provided the manager with a mechanism to obtain others views. Satisfaction surveys provided the opportunity for others to air their concerns or express praise in a formal manner. It meant they were given a voice to air their thoughts and feelings. Relatives and professionals felt able to approach the manager. Though resident meetings as such were not held we still got the strong impression that people's views and interests were sought and considered in other creative ways to contribute towards the running of the home. For example, key working duties, allocations and responsibilities had changed in response to feedback.

The visions, values and philosophy of the service were readily available to see. There was a statement of purpose which detailed the philosophy of the service. This included providing a person centred approach to support so that each person achieved their individual goals. This was available for people and their relatives to access or view, most visibly displayed in the entrance hallway. Staff talked to us about the strong values base of 4 Vallance Gardens and the provider, the Care Management Group. This converted into a clear commitment to providing individual support. From talking with staff it was clear they had spent time getting to know each person, their likes, dislikes, personality and individual support needs. One member of staff told us, "People are so valued. I think enough of this place that if my [relative] were here I would be happy and I don't say that lightly. "

The manager was committed to on-going improvement in the service and was able to describe key challenges looking forward. Concerns found during the inspection were discussed with them and throughout the manager open and responsive to the concerns. The manager told us, "I am fortunate to have a dedicated team who always put one hundred percent into delivering good quality support. We've got where we are by sheer hard work and determination but there is always room to improve and today the inspection has provided just that, a chance for us to go on getting better."

Management were visible within the home. The manager and newly appointed deputy manager regularly provided support on the floor and interacted with people, relatives and representatives. People appeared relaxed in the company of the manager and it was clear they had built a rapport with individuals for whom they expressed a great deal of respect and affection. On a day to day basis, the manager provided the guidance and leadership required to

Requires improvement

Is the service well-led?

maintain a well led service. In the absence of the manager or deputy and at weekends, a team leader was identified to lead the shift with the managers providing on-call support. The Regional Director and Chief Executive were known and recognised by staff as regular visitors, especially following the period of recent bereavement and the manager commented they felt supported and valued by the provider. The Regional Director completed structured monitoring visits and used the provider's quality auditing tool to review the service. Actions arising in areas as diverse as safeguarding, service user documentation and management of medicines were recorded with a timescale for response and review, if appropriate.

Communication within the home was valued and respected. Staff meetings were held regularly and we sat in on one held on the day of our visit. It was led by the manager. It followed a clear agenda, considered the topics raised at the previous meeting and was an open and transparent meeting. This provided staff with the forum to air any concerns and to discuss practice issues. In between each shift, daily handovers were held, which enabled staff to keep up to date and informed of any developments or changes to people's needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not protected people against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).