Deepdene Care Limited

Deepdene Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 December 2017 and was unannounced. Deepdene Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. Deepdene Court is registered to provide care and accommodation for up to 36 people who have a range of mental illnesses, including people who have complex and enduring needs as well as substance misuse needs. The home is divided into two buildings, St Catherine's and Fieldings. St Catherine's accommodates people who also require nursing care. On the day of the inspection there were 27 people living at the home.

The home had a registered manager who was present throughout the 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.

At the previous inspection on 21 and 23 June 2016, the overall rating for the service was Requires Improvement. We found a number of areas of practice that needed to improve and one breach of regulations. This was because the provider had not ensured risks to people were fully assessed and action taken to mitigate those risks. The provider sent us an action plan explaining how they would meet the requirements of the regulations by 30 November 2016. At this inspection we found that they had taken actions to address the breach of regulations and the quality of the service had improved.

People told us they felt safe living at Deepdene Court. One person said, "It is safe here, they look out for us." Another person told us they felt "protected," by the staff. Risks to people were assessed and managed to support them to stay safe. Staff demonstrated a firm understanding of their responsibilities with regard to safeguarding people. One staff member said, "Anything at all that was worrying I would report to the nurse on duty or to the manager." People's medicines were managed safely and people were protected from risks of infections. There were enough staff on duty to care for people safely and there was a calm atmosphere in the home. The provider had robust systems for recruitment and staff had a thorough induction before starting to work with people. Incidents were recorded, monitored and analysed to support development of the service.

Staff received the support they needed and training was relevant to the needs of the people they were caring for. There were effective systems in place to support communication between staff and with other professionals involved in the care of people at the home. Feedback from professionals described positive partnership working with staff at the home. People were supported to access health care services when they needed to.

People's needs and choices had been assessed in a holistic way to include consideration of all aspects of

their life. Risk assessments and care plans reflected people's diverse needs including their cultural needs and religious beliefs. People spoke highly of the food provided at the home and we observed that the lunch time meal was a positive social experience for people. Staff supported people and offered choices including about when and where they wanted to eat. Specific dietary needs or preferences were accommodated.

Staff demonstrated a firm understanding of their responsibilities with regard to the Mental Capacity Act 2005. Consent was sought before providing care and where people lacked capacity to make specific decisions mental capacity assessments and best interest decisions had been recorded in line with the legislation and guidance.

People spoke highly of the staff at the home their comments included, "They are all very helpful," and, "They are really kind and they do a good job." Staff treated people kindly and respected their right to privacy. Staff had developed positive relationships with people and knew them well. Staff spoke compassionately about people, one staff member said, "I know about certain events that had a real impact on them, they tell me about things and I know the signs when they are low." People told us they had been included in developing their care plans and records showed people's views and preferences were reflected. Staff supported people to remain as independent as possible. One staff member said, "The idea is that we support people, enabling rehabilitation and recovery so they can move on. We might help them with some things but it's about encouraging them and keeping them motivated towards their goals." People who had communication needs were supported to access information that they needed.

People's care plans guided staff to provide care in a personalised way. Staff were able to tell us about numerous small details that demonstrated that they knew people well and we observed that people were receiving care that was personalised according to their needs and wishes. People were supported to make plans for their future including for end of life care. Staff recognised when changes indicated a decline in people's mental or physical health and took appropriate action to adjust care or to seek advice from health care professionals. People told us that they knew how to make a complaint and were confident that their concerns would be listened to.

People spoke positively about the registered manager. One person said, "The manager is brilliant," another person said, "They are very good." Staff said that the home was well run and described clear management structure and visible leadership. The aims and objectives of the service were embedded within staff practice and staff demonstrated a clear understanding of their roles and responsibilities. There were effective management systems and processes in place to monitor the quality of the service. The registered manager used analysis of incidents and accidents to learn and drive improvements. Staff had developed positive links with the local community and worked effectively with other agencies.

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.

Risks were identified and managed. Incidents and accidents were monitored.

Staff understood their responsibilities with regard to safeguarding people.

There were enough staff on duty to care for people and people's medicines were managed safely.

Infection control procedures were robust.

Is the service effective?

Good

The service was effective.

Staff received that support and training they needed to be effective in their roles. They understood their responsibilities with regard to the Mental Capacity Act.

People's needs were assessed in a holistic way and regularly reviewed to ensure care plans were up to date and accurate.

People were supported to have enough to eat and drink and to access health care services when they needed them.

Staff worked effectively with external organisations to deliver effective care. The building was suitable for people's needs.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach and had developed positive relationships with people.

Staff treated people respectfully, maintained their privacy and supported their dignity.

People were supported to express their views about their care

and support. Staff respected the decisions that people made.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and provided care in a person-centred way. Staff recognised and responded to changes in people's needs. People were supported to make plans for their future including for end of life care.

People were supported to maintain their hobbies and interests and to access the local community.

People knew how to make complaints and were confident that staff would take actions to resolve their concerns.

Is the service well-led?

Good

The service was well-led.

Governance arrangements and management systems were effective in monitoring the quality of care. Learning from mistakes and omissions was used to drive improvements.

The vision and values of the service were embedded within staff practice. Staff and people were involved in developments.

Staff had made links with the local community and worked effectively with other agencies.

Deepdene Court

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 5 December 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using, or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service including any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) before the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We contacted two professionals who had involvement with people living at the home to gather their views. This enabled us to ensure that we were addressing any potential areas of concern at the inspection.

We spoke to six people who use the service and one relative. We interviewed five members of staff and spoke with the registered manager. We looked at a range of documents including policies and procedures, care records for seven people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We spent time with people and making observations around the home. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the provider's information systems.

Good

Is the service safe?

Our findings

At the last inspection on 21 and 23 June 2016 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that risks to people were fully assessed and action taken to mitigate those risks. The provider sent us an action plan explaining how they would meet the legal requirements by 30 November 2016. At this inspection we checked to see if the provider had followed their action plan. Improvements had been made to the risk assessment process and systems were in place to ensure that risks were identified, assessed and managed; therefore the provider had addressed this breach.

Staff monitored risks to people and kept accurate records to ensure that any changes were highlighted. Staff members told us that communication systems were effective in identifying changes that might indicate increased risks. This meant that people's needs and risks were kept under regular review. Risks associated with peoples' mental health were identified and potential signs or triggers that might indicate a decline in their mental health were documented. Care plans included guidance for staff about what actions to take in such a situation. For example, one person needed to take prescribed medicines regularly to maintain their mental health wellbeing. The risk assessment clearly identified signs that might indicate a relapse and what actions should be taken to support the person.

Some people's mental health problems meant they were at risk of harming themselves and this was identified in their care plan. The staff we spoke with were able to tell us who was currently unwell and what the increased risks were for those people. They were aware of the care plans that were in place to support people, including additional monitoring, changes in medicines and specific strategies for supporting people who were unsettled or low in mood due to changes in their mental health.

Some people needed support to manage behaviour that could be challenging to others. Risk assessments identified possible triggers for such behaviour and gave staff clear guidance in how to avoid potential incidents as well as detailing actions to take in the event that an incident occurred. For example, particular risks were identified around a person using craft equipment. A specific risk assessment identified how tools should be used. The person had been involved in developing measures to limit any opportunity for tools to be misused and to manage the risk. This enabled the person to continue to enjoy their interest safely and ensured that other people were protected.

Some people were living with long term physical conditions such as diabetes. Risks associated with their health were assessed, monitored and regularly reviewed. Records confirmed that people were regularly weighed and clinical checks such as blood pressure and pulse were measured and documented. Progress notes were completed regularly and any changes were noted to inform reviews of risk assessments and care plans to ensure they remained accurate and met people's needs.

Environmental risks were also assessed, monitored and managed. For example, the provider had a policy and procedure for identifying possible ligature points around the home that could be used by people who were at risk of self- harm or suicide. Any windows above the ground floor level of the home had a restrictor

fitted to ensure that people could not fully open the window. A fire risk assessment had been completed and was regularly reviewed. Regular checks on the fire alarm system were recorded and a fire drill had included people living at the home. People were aware that there was a no smoking policy at the home. Staff undertook regular checks to ensure people were complying with the policy and notes from resident's meetings showed that this issue was regularly discussed to ensure risks of fire were minimised. Each person had an individual personal emergency evacuation plan (PEEP) in place to identify the support they would need in the event of an emergency evacuation.

Incidents and accidents were recorded and monitored. Actions were taken to review risk assessments and care plans to ensure similar risks were managed appropriately. For example, one incident showed that a person had fallen. Advice was sought from their GP and the falls assessment team to ensure that the person's risk assessment and care plan continued to meet their needs. Some incidents were related to people's behaviour and actions were taken to review what had happened. This included analysis to identify any possible triggers or causes for the behaviour . Learning from this process determined what additional or different support the person would need to prevent or reduce risks of a reoccurrence. Changes included amendments to care plans, use of different strategies and where needed, additional training for staff. This showed that analysis of incidents and accidents provided opportunities for learning and improvements to the service.

The registered manager explained that some people's behaviour had resulted in damage to furniture and furnishings around the home. Systems were in place to monitor faults or maintenance issues relating to the fabric of the building. This showed that action was taken swiftly to repair or replace damaged items to ensure the comfort and safety of people living at the home. For example, mattresses were replaced regularly when they became soiled. Some communal areas of the home were in need of refurbishment and the registered manager confirmed that plans were in place to redecorate and replace carpets in some areas.

Some people were reluctant to accept support with cleaning their rooms. Staff told us that they offered support to help people to keep their bedrooms clean and tidy but not everyone accepted this help. Where this resulted in infection control risks staff explained that a deep clean of the room was completed at least on a weekly basis and more often if required. Schedules were in place to ensure all areas of the home were regularly cleaned and checked to reduce risks of infection and maintain a safe environment. Some people made life style choices that could present additional infection control risks. Records showed that staff respected people's rights to make such choices however they took steps to encourage and support people to maintain their personal hygiene and reduce risks of infection.

Staff demonstrated a firm understanding of their responsibilities to safeguard people from harm and abuse. One staff member said, "We know people very well. I would recognise signs of abuse, changes in their mood, bruising or money going missing. Anything at all that was worrying I would report to the nurse on duty or to the manager." Safeguarding issues had been reported to the local authority in line with local safeguarding procedures. People told us that they felt safe living at the home, one person said, "It is safe here, they look out for us." Another person said, "It's very safe and they deal with things fairly." A third person told us that they felt "protected" by the staff. A visiting relative said that they always felt safe when visiting the home and that they felt their relation was safe. They told us, "It always feels very safe here and I know staff would take my relation out of harm's way if they needed to." People told us that they had not experienced any bullying or aggression whilst at the home. One person spoke about disagreements between people, they told us, "Sometimes people squabble, it's usually about the TV but staff sort it out." A relative told us, "I know there is no bullying tolerated here." Our observations throughout the inspection were that the atmosphere in the home was calm and friendly. People appeared to be relaxed and comfortable in their surroundings with no indications of tension or friction evident.

The registered manager used a tool to assess how many staff were needed to care for people safely. They explained that staff levels were always maintained and only familiar staff were used to cover shifts. People told us they thought there were enough staff on duty, a visiting relative said, "I think staffing levels are adequate, there are always staff around." Records of staff rotas confirmed that consistent staffing levels were maintained. Agency staff were used but only when they had completed an induction and were familiar with the home and people's needs. The registered manager explained, "We have to manage some potentially serious risks and we need staff that are familiar with people's needs and our procedures, it would not be safe to have unfamiliar staff here." We noted that an agency nurse was visiting as part of an induction to the home on the day of the inspection. Staff told us that there was always enough staff to care for people safely. One staff member said, "There are plenty of staff, we cover for each other and it's a tight team." Another staff member told us, "If we need more staff because someone is unwell, we get them; there is no problem with staffing now." We asked staff about their induction when they joined the team. One staff member said, "It was a good induction, I shadowed experienced staff and had time to read information in peoples' files, so I was well prepared. You are never left on your own; there is always staff around to support you."

The provider had a robust recruitment system. Staff records included application forms, previous work history, records of interview and appropriate references. Checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with people. Recruitment checks included professional registration checks for nurses to ensure they were appropriately registered with the Nursing and Midwifery Council. Records seen confirmed that staff members were entitled to work in the UK.

Peoples' medicines were managed and administered safely. Medicines were stored securely and temperatures were monitored to ensure that storage facilities remained within the required temperature range. We observed medicines being administered safely by staff who were trained and assessed as competent in the task. The provider used an electronic system for managing medicines. The registered manager explained that this provided increased opportunities for oversight as they were able to log into the system and check that medicines had been administered. The provider worked with a local pharmacy who undertook medicine audits regularly. Some people were receiving PRN (as required) medicines. There was clear guidance for staff about when and how such medicines should be administered. For example, one care plan included information about how staff would recognise that a person was becoming anxious and should be offered their PRN medicines. This included a description of the person's behaviours, facial expressions and body language. Another medicines risk assessment included specific guidance for staff about supporting a person who had expressed concerns about taking their medicines. Staff were aware to present the person with their medicines in a specific way to reassure them.

People were being supported to take positive risks, for example, some people were able to self – medicate. One staff member said, "We are trying to support people to maintain or regain their independence. Sometimes they have been in hospital and they have all their medicines administered and then they come here and we support them to take back control. It's important for people's confidence and self-esteem."

Good

Is the service effective?

Our findings

At the last inspection on 21 and 23 June 2016 we found that the service was not always effective. This was because staff had not received training specific to people's needs, mental capacity assessments were not always completed and staff did not have the guidance they needed about nutritional risks. At this inspection the provider had addressed these shortfalls and the service was effective.

People's needs had been assessed in a holistic way to include their mental, physical and social needs. One person told us, "I discussed it all with my support worker; I can have a copy of the care plan if I want it." People's views and choices were included and reflected throughout their care records. Details included their daily routine and preferences such as hobbies or activities that they enjoyed as well as rehabilitation goals that they were working towards. For example, one care plan identified specific tasks that the person wanted to undertake to increase their skills and to work towards their goal of becoming more independent. People's cultural and religious needs and beliefs were considered and respected. One person told us his faith was important and that staff respected his views.

People spoke highly of the food at the home. One person said, "I like the food, there's always some sort of choice. They write it on the board. " Another person said, "It's good food here." A third person said "The food's alright, not bad." People said there was always food and drink available between meals if they wanted it. One person said, "They lock the kitchen at 10pm but you can still have a drink in your room if you want to." We saw that there was a bowl of fresh fruit available for people to help themselves.

Some people had particular dietary needs and staff told us that the chef was aware of everyone's needs and preferences for example, some people had particular cultural and religious beliefs and required a special diet which was recorded in their care plan. A staff member told us that one person preferred to buy their own food and drinks from a local shop and another person sometimes enjoyed preparing and cooking their food with some support from staff. Some people had specific risks associated with nutrition and hydration and their care plans reflected particular needs. People's weight was regularly monitored and a staff member told us they kept food diaries to monitor people's intake if they had concerns about their weight.

We observed the lunchtime meal. People were able to fill their plates themselves and were offered a choice of food. Staff were on hand to support people who needed help with serving food. Some people had their food brought to them by staff and we heard them being offered choices. Drinks were also available for people to serve themselves and staff were available to support with this if needed. People were able to choose where they wanted to sit and eat, for example some people were eating in the garden. Staff were seen to be checking that people had what they needed and offering help and support throughout the meal. People were chatting with staff and with each other, the atmosphere was relaxed and people were clearly enjoying the social experience. Staff told us that people were involved in deciding what food should be on the menu and we saw this was reflected in notes from resident's meetings for example, people had requested a continental breakfast at the weekend and another asked for different cheese and biscuits to be added to the menu.

Staff told us that there were supported with the training they needed to be effective in their roles. One staff member said, "We have regular training and it is very relevant to our job, for example, I have had training in mental health but I also received additional training in specific illnesses such as diabetes and Korsakoff disease." Another staff member said, "The training is very good." Records confirmed that staff training was regular and relevant for the needs of people living at the home. Nursing staff had access to opportunities for professional development. One member of staff told us, "The induction before starting work here was very thorough and I have supervision and appraisal meetings on a regular basis." Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Records showed that staff were receiving supervision regularly and annual appraisals were in place to identify staff development needs. One staff member said, "Management support is very good. I have regular meetings for supervision and we can talk to the nurse or manager at any time."

Staff described strong working relationships with other professionals involved in people's care and support. Some people were subject to Community Treatment Orders (CTO) which allows people to receive treatment for their mental health in the community rather than in hospital. People are required to comply with specific conditions attached to a CTO. Where these arrangements were in place, care records reflected the conditions and guided staff in how to support people appropriately. For example, one person had a CTO which required them to take their medicines regularly at the time and in the way prescribed, to ensure that therapeutic levels were maintained. There was clear guidance for staff about how to support the person with this and who to contact in the community psychiatric team if there were any issues. Staff described building effective relationships with professionals in the community mental health teams including Psychiatrists, Community Psychiatric Nurses (CPN), Occupational Therapists and Psychologists. A professional from the probation service described positive partnership working with staff at the home. They described how they had worked with staff to support one person to make a positive change. They said that this had taken time but had proved to be, "A successful solution to a specific issue."

People told us they were supported to access health care services when they needed to. One person said, "Yes, I have been in hospital recently." Another person told us, "They will contact my CPN if I need them to." Staff told us that people received support with health care appointments. One staff member said, "We might have to attend with people, some can go on their own but others need our support. For example with the optician or dentist." A health care professional told us that they had received appropriate referrals from staff at the home. We saw that people had access to regular GP appointments and a staff member told us that they would contact a Tissue Viability Nurse (TVN) if they needed support or advice regarding wounds or skin integrity issues. A nurse specialising in heart failure was visiting on the day of the inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

Staff had received training in MCA and DoLS and understood their responsibilities. One staff member told us about supporting someone whose capacity to make certain decisions could fluctuate. They described offering choices and seeking consent and explained the importance of being able to interpret non- verbal

communication such as facial expressions, when the person became withdrawn. We observed staff checking with people before providing support and respecting their decisions.

Where people were unable to make decisions for themselves, staff had considered the person's capacity under the Mental Capacity Act 2005, and had taken appropriate action to arrange meetings to make a decision within their best interests. For example, some people were choosing to smoke tobacco regularly. We observed that people were asking staff for access to their cigarettes and staff explained that this system was in place to help people to limit the number of cigarettes that they were smoking. Most people had consented to this arrangement. Where people were not able to consent, a best interest decision was recorded to confirm that staff should limit the number of cigarettes for example, due to a person's specific health needs.

Some people were not able to leave the building without staff support. Referrals had been made for Deprivation of Liberty Safeguards (DoLS) and we could see that staff understood how these were implemented. People told us that they had access to advocacy services. One person said, "Social services arrange advocacy for me." This meant that people were being supported to make decisions or to have a representative to ensure their best interests were considered.

Some people needed support to manage behaviour that could be challenging to others. On some occasions people could be physically aggressive towards staff or other people. The provider's policy was that staff were not to physically restrain people. Staff told us that they used different techniques to de-escalate tensions and that this strategy was usually successful. One staff member said, "We have all received break-away training and we know people well so we can recognise when tensions are rising." The registered manager said that staff were skilled in recognising when to intervene and used verbal prompts and distraction techniques when necessary to keep people safe. Any incidents were recorded and monitored by the registered manager to ensure that interventions were appropriate. Individual risk assessments and care plans were reviewed with involvement from relevant professionals to identify any possible triggers or measures to prevent a re-occurrence.

The building was suitable to meet people's needs. Each bedroom had on-suite bathroom and toilet facilities to maintain people's privacy. Communal lounge and dining areas were comfortably furnished and decorated. People were able to access the garden independently. The registered manager told us that regular checks of the premises were made to ensure the fabric of the building remained safe and plans were in place to refurbish the hallways and stairwells which were showing signs of wear and tear. People had access to quiet areas where they could talk privately to visitors or professionals. A games room was available for people to use for example, to play pool or when doing art or craft work. Staff explained that the open aspect of the lounge and other communal areas, allowed staff to monitor people discreetly to ensure their safety.

Good

Is the service caring?

Our findings

People and a relative told us that the staff were kind and caring. One person said, "They are all very helpful." Another person said, "They are really kind and they do a good job. I think the staff are very loving." A third person said, "The staff here are so good." A relative told us they felt staff were very caring and interested in people's well- being.

Staff spoke about people with warmth and compassion. One staff member said, "The people here are a nice group, it's a family atmosphere, and we all get along well. There are some real characters and they look out for each other. It's a good place to work." A key worker system was in place, which enabled people to have a named member of the care staff to take a lead and special interest in the care and support of the person. Staff demonstrated that they knew the people they were caring for well. One staff member described a person's background and was able to tell us about significant events in their life. They said, "I know about certain events that had a real impact on them, they tell me about things and I know the signs when they are low." Another staff member described how they supported a person to remain independent and described challenges that they faced. They explained, "It's because of their history, I can understand why they find certain things difficult to manage and they need support."

People told us staff were respectful. One person said, "They are always respectful and very kind with me." Our observations throughout the inspection confirmed this. We saw staff knocking on people's doors and waiting for a response before entering. Staff were heard using people's preferred names and speaking to them respectfully. Staff were seen to be gentle in their approach to people. For example, we noted that one staff member asked permission before sitting next to someone. Staff told us that they recognised if people were feeling upset and would offer support and opportunities to talk about what was troubling them. Staff told us about how they had supported people when a person who lived at the home had passed away. A small meeting had been held to let people know about the remembrance service and arrangements for people to attend if they wished. Staff said they offered support and had told people that they were available to talk to at any time day or night. This was confirmed in the notes from the meeting.

People told us they were provided with information they needed to help them to make informed decisions. One person told us that staff had supported them to access an advocacy service. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. Records showed that other people had also received support from advocates when needed.

One person told us their keyworker provided any information they needed. Examples they gave included information about transport and local events. They confirmed that this helped them to remain involved and to prevent them from becoming isolated. People told us that staff supported them to be involved in making decisions about their care and support. One person told us that they had difficulty with verbal communication and relied upon their key worker to help them. Another person said, "I have a care plan, I am ready now to start a discharge plan to move on." A third person told us they had been involved in developing their care plan and decisions about their care. They told us "I sometimes agree and sometimes I

disagree, but I am included."

Care plans reflected people's differences and considered their views and preferences. For example, one care plan described how a person disliked feeling pressured and preferred to make decisions in their own time. Another care plan guided staff in how to support a person to make choices that supported their social needs. This included an activities planner that identified how they preferred to spend their time.

The provider's statement of purpose described a goal of the service as, ' To promote individual's independence through safe and achievable steps towards a more independent lifestyle.' We asked staff how they supported people to remain as independent as possible. One staff member said, "The idea is that we support people, enabling rehabilitation and recovery so they can move on. We might help them with some things but it's about encouraging them and keeping them motivated towards their goals." Another staff member said, "Sometimes we just need to remind people to keep appointments, other people need more help and we have to go with them. It's individualised support depending on what people need." A third staff member told us, "It's important that people do what they can and we help them to recover by keeping their independence. For example, some people are able to self-medicate, we monitor them to make sure it's safe but they do it themselves. They will need to do that if they are going to live alone and it builds their confidence. " This showed that staff had a good understanding of the provider's recovery model.

Staff understood the importance of supporting people to maintain their privacy and to protect their dignity. People's confidential information was kept securely and space was provided for people to discuss their needs or concerns with staff privately. People were supported to maintain their appearance and personhood. A staff member told us that some people made lifestyle choices that could impact upon their dignity. The explained that if staff noticed, for example, that someone was wearing soiled clothes they would discreetly remind them to change before leaving the building and offer support if appropriate. This approach was evident in people' care plans and in the daily records that staff completed.

Good

Is the service responsive?

Our findings

People were receiving care that was personalised according to their diverse needs and preferences. Care plans were person centred and reflected the individual's voice. For example, one care plan described the person's daily routine and included details of the time the person liked to get up, the order that they preferred to do things, details of activities and interests and specific likes and dislikes, as well as guiding staff in the level of support that was required. Details that were important and relevant to the person were specified. For example, one care plan identified that a person preferred to use their own electric shaver. Another care plan identified a person's preference for taking a nap after lunch. Care plans were in a format that was accessible for people and they told us they had been given a copy of their care plan or that they would ask staff if they wanted a copy.

Staff were able to tell us about numerous small details that demonstrated that they knew people well and we observed that people were receiving person centred care. For example, one person did not eat their main meal at lunchtime. A staff member told us that this was because the person preferred to sleep during the day and was awake at night. They explained that the person usually had their main meal in the evening or later as that is what he preferred to do. Another person was described as being reluctant to accept help with their personal care. Staff told us that the person had developed a positive relationship with a member of the night team and as a result they were usually offered support with their personal care at night because they had built a trusting relationship with that particular staff member.

Staff told us about indications and signs that they noticed when a person was having a relapse of their mental health. They described small changes in people's behaviour or character that identified when someone was not well and described how this was communicated to other team members. The provider's electronic care planning system included a facility to send a "Message of the day" to alert staff of any significant changes that they needed to be aware of. This included changes to people's physical or mental health needs and any resulting changes to their care plans. The registered manager said that staff were skilled at recognising small changes and in monitoring people's health. Records showed that staff took appropriate action to adjust care or to seek advice from health care professionals when people's needs changed.

Care records included people's wishes for the future and end of life care. Staff told us that not everyone wanted to discuss their wishes but some people had identified specific information that was important for them. For example, one end of life care plan included details of a particular undertaker that a person preferred and noted their wish to be cremated not buried. The plan also included the person's stated preference for where they would prefer to die and their religious beliefs.

People told us that they enjoyed the range of activities on offer at the home. An activities co-ordinator was responsible for arranging events and outings and they told us that people's ideas, preferences and interests were considered as part of the planning process. There was a wide age range between people living at the home and activities were arranged to suit the diverse interests and ages of people. Notes from residents meetings confirmed that people were able to make suggestions about events and places they would like to

visit. Some ideas included visiting local garden centres, cinema, bowling and coffee shops in town. The activities calendar showed that people's ideas were included and on the day of the inspection people told us they had been out to a coffee shop in the morning and were going on a bowling trip later in the day.

As well as being supported with organised activities people were also supported to follow their individual interests and hobbies. For example some people enjoyed art and craft activities and others liked music and collected electronic gadgets. Staff supported people to pursue their individual interests and risk assessments were in place where appropriate to ensure people could continue to enjoy these leisure activities safely. Some people were supported to access adult education. A staff member told us, "We made links with a college offering short courses. If we can help people to attend we will."

People went out and about in the local community regularly. For example, staff supported people to go to local coffee shops and told us that as people spent more time there, the atmosphere had become more welcoming and people felt empowered to visit with staff and on their own. Staff said this had a positive impact in reducing social isolation and stigma associated with mental illness. People told us that they enjoyed being able to go to local café's for drinks and snacks. One person told us they liked to go out in the town "As often as possible." Another person told us that "Everyone enjoys going out for coffee mornings."

People were supported to undertake day to day tasks such as cleaning their bedrooms, ensuring used plates and cutlery were washed-up and taking clothes to be laundered. People had specific goals that they were working towards to improve their levels of independence as part of their care plan to support recovery and regain skills. For example, one person was supported to buy food at a local shop and then to prepare and cook a meal. Care plans were regularly reviewed with people to determine their progress and set new goals. Staff told us about how some people had successfully achieved their goals and had moved on to more independent living facilities.

People told us that they knew how to complain and would feel comfortable to raise any concerns they had. People told us they would speak to staff members; some identified their key workers as the staff member they would approach. Some people said they would speak to the registered manager if they had any complaints. One person told us, "I will complain in order to change things, when there is a need." There was a complaints system in place to record any issues and identify how they were resolved. No complaints had been received from people living at the home.

Good

Is the service well-led?

Our findings

People and a relative all spoke highly of management at the home. One person said, "The manager is brilliant." Another person said, "They are very good." A relative told us, "The manager keeps me informed and I feel I am very much involved." Staff members also spoke positively about the management of the home. One staff member said, "The manager and the deputy are both very approachable and easy to talk to." Another staff member said, "Management support is very good, and things run smoothly here. The organisation is good and the home is well run. "

There was a clear management structure and staff understood their roles and responsibilities. Staff described visible leadership throughout the home. One staff member said, "Things have improved since this manager came, things are better organised and staff all work together. There is no feeling of them and us, the managers muck in with the rest of us." At the last inspection on 21 and 23 June 2016 the provider had not sent relevant information about planned changes to CQC. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. At this inspection we found that the registered manager had informed the CQC of significant events in a timely way and this included submitting an action plan following the last inspection. This meant we could check that appropriate action had been taken.

The vision and values of the service were described within the provider's statement of purpose as providing support to people in an enabling way to recover from mental illness and reintegrate back into the community. Staff demonstrated a clear understanding of their roles and throughout the inspection our observations confirmed that these objectives were embedded within staff practice. People were supported to achieve individual goals that were appropriate for them and their aspirations. One person spoke about wanting to live more independently. They said, "I need attention at the moment because I know I am not well but I want to have my own flat." They went on to tell us what they felt they needed to achieve before they could be more independent. Their care plan reflected their aspirations and staff demonstrated their awareness of the person's identified goals.

Communication systems were effective within the home and with outside agencies. Staff reported positive working relationships with a range of professionals who were involved in the care of people at the home. A health care professional and a probation officer confirmed positive communication with staff at the home.

People were receiving help and support to access the local community. Staff had made positive links with local businesses and services to encourage an inclusive environment. For example, one staff member described building relationships with local café owners. They explained that staff in local shops had got to know people, and told us, "They recognise people and would contact us if they were concerned about anyone. That's a good thing because some people here are really very vulnerable." Another staff member told us about other connections with local people and groups and how this helped to raise awareness and reduce stigma about mental illness. They explained, "We try and support people to get out as much as possible with trips to local facilities and events." Staff told us that they also invited local people to visit the home to get to know people. One staff member said, "The community police officers come in for a chat

sometimes, which is really helpful for residents to get to know them and for the officers to be able to recognise them. If someone gets into difficulty when they are out in the town it can help if the police officer is familiar to them."

The provider had a robust governance framework in place and this included a range of audits to check the quality and standards of the care provided. For example, a health and safety audit was completed to provide the registered manager with assurance that regular checks were completed and necessary risk assessments were in place and had been reviewed and updated. Where errors or omissions were identified the audit specified actions that were taken to address the issue. The registered manager had oversight of all audits and had developed action plans to drive improvements. For example, records of incidents and accidents were analysed to identify the type of incidents and accidents that had occurred and the frequency and intensity of the incidents. This information was used to inform developments such as staff training, reviews of individual care plans and any considerations for reviewing policy and procedures. This showed that the registered manager was using learning from incidents to continuously improve the service.

Staff described being well motivated in their roles .One staff member said, "I am determined to make things work for the service users." Staff told us that they felt able to raise their views and contribute to plans for developing the service. One staff member told us, "Everyone's views are valued." Another staff member said, "We told the manager that we could do with an additional staff member to help during the evening and now we have an extra person for the twilight shift, so they do listen and take us seriously." Staff told us that morale within the team was good and our observations were that staff appeared relaxed and happy within their roles.

The registered manager was committed to keeping up to date with best practice and updates in health and social care. They were also aware of our revised Key Lines of Enquiries that were introduced from the 1st November 2017. The registered manager was aware of their responsibilities under their registration, including with regard to the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.