Sanctuary Home Care Limited

Maryfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Maryfield is the stepping stone to independent living, working in partnership with Uplands Educational Trust and Sanctuary Housing Group. Maryfield provides personal care for up to 11 young people who have a tenancy on a self contained flat in one building. At the time of our inspection 11 people were living at Mayfield's and five of these people were being supported under the registered regulated activity of personal care.

The inspection took place on 27 and 28 September 2016.. This was an announced inspection, which meant the provider was given notice. This was because the location provides a supported living service to people in their own flats and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf. The service had not previously been inspected.

A registered manager was employed by the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and staff were responsive to their needs. Systems were in place to protect people from abuse. Staff had a good understanding of safeguarding and whistleblowing procedures. They knew how to report concerns and had confidence in management that these would be fully investigated to ensure people were protected.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. This had been regularly reviewed and was signed by the person concerned to show their agreement.

The training record showed not all staff had received updated medicine training, and there was confusion over if staff had recently attended. The registered manager took action by booking these staff members onto the next available course and removing them from administering medicines until this training had been completed.

Documentation relating to mental capacity assessments and best interest decisions had not been kept on people's files at the service to ensure that staff acted in accordance with decisions made. The registered manager sourced this paperwork from the relevant authorities and we were able to ensure people were being appropriately cared for.

People's changing needs were monitored to make sure their health needs were responded to promptly. Health action plans were in place which recorded any medicines people were taking and health appointments attended.

People told us they were happy with the care they received. One person commented "I would not have had

the confidence to speak to you before I came here". Staff encouraged people to be independent and take responsibility over their daily activities. Relatives also commented that their loved one's had become more independent.

Information relating to people's needs in care plans had not always been fully completed or documented. We saw examples of inappropriate terminology and systems in place to describe and monitor people's behaviour.

The service had good links with the local community. Staff were proactive and made sure that people were able to maintain relationships that matter to them.

Not all reportable incidents about significant events had been notified The Care Quality Commission (CQC). This information is used to monitor the service and ensure they responded appropriately to keep people safe. Notifications that had not been received included incidents of abuse, incidents with police involvement and events that stop the service from running as it should be.

We found one breach of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff had a good knowledge of safeguarding and were confident in reporting any concerns they had.

Staff had been recruited following safe recruitment procedures. This ensured they were safe to work with people before they began their employment.

The provider had systems in place to ensure people received their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Training records showed that not all staff had completed up to date training in safe handling and administration of medicines.

Mental capacity assessments and best interest decisions paperwork was not in place at the service. This information had to be obtained from people's social workers.

People's health care needs were assessed. Staff recognised when people's needs were changing and worked with other health and social care professionals to make changes to their care package.

Is the service caring?

Good

The service was caring.

People spoke positively about the care they received and told us staff had supported them to be more confident.

People had been encouraged to make and be involved in decisions about their care.

People said they were treated with dignity and respect. Staff told us how they aimed to provide care in a respectful way whilst promoting people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information relating to people's needs in care plans had not always been fully completed or documented.

There were examples of inappropriate terminology and systems in place to describe and monitor people's behaviour.

People had access to activities both within the home and their local community.

People received regular reviews of their care needs and the service was responsive in implementing changes to support people effectively.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications of events and incidents had not been made in line with regulations.

The registered manager demonstrated the service values, which were person focused. Staff had a good understanding of the aims and values of the service and had opportunities to express their views in the open culture created.

There were systems in place for monitoring the quality of the service to ensure people received a good standard of care and support.

Maryfield

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 27 and 28 September 2016 and was an announced inspection, which meant the provider was given notice. This was because the location provides a supported living service to people in their own flats and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

This inspection was carried out by one inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. This service had not previously been inspected. Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with six people and four relatives about their views on the quality of the care and support being provided. We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included
five care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents.

We looked around the premises and observed care practices throughout the day. During our inspection we observed how staff supported and interacted with people who use the service. We spoke with the registered manager, the deputy manager, and five care workers. After the inspection we contacted health and social care professionals the service worked alongside, and received feedback from one health professional.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Maryfield. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Comments from staff included "I would take any concerns to my supervisor or manager, and if necessary go higher up. I have had safeguarding training", "I would report to my manager, I feel confident to whistleblow or take it to the area manager" and "I would inform management and if I felt it wasn't dealt with I would go higher or go to safeguarding". Whistleblowing is a dedicated phone number that workers can call to report certain types of wrongdoing.

The registered manager had a safeguarding folder in place, which contained contact details for the service's safeguarding lead. Information was available on the types of abuse a person may experience and a flowchart for the reporting process to follow.

We saw one example of unsafe practice where financial documents relating to people's personal accounts had been kept in care plans which were accessed by all staff members. We raised this with the registered manager that this increased the potential for financial abuse to occur. The registered manager agreed this information could be kept in a more secure place with access limited to management staff.

Each flat had an intercom system so people could be in contact with staff if they needed. Pull cord alarms were in all areas of people's flats should they need to raise the alarm in an emergency. The front door was unlocked during the day so people could come and go freely but an alarm could be put on the door to notify staff if someone entered or exited so they could be aware who was out or in the building. Staff were present in the building 24/7 so people had support if they required.

Staff worked with people to explain the importance of maintaining their own safety. For example one staff told us they supported a person to go shopping but this person would always leave their bag unattended. The staff had spent time explaining to the person that this was not a safe thing to do and now the person was very careful to watch their bag at all times when out. Another member of staff told us "We look after some people's money, it is kept in a locked safe and we complete weekly cash sheets. When we take the money out we always have two signatures. This is checked weekly to see the money left is correct and the receipts are recorded and reference numbers wrote on them". During our inspection we saw appropriate measures being followed by the registered manager who counted and checked the money a staff member had taken out. The registered manager told us "We sit and talk to people and do scenarios of fire practices, keeping safe around cookers, kettles, and road safety awareness".

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example one person had a risk assessment and management plan in place for when they travelled by car. Risk measures had been put in place such as ensuring staff had the appropriate insurance in place to drive, if the necessary maintenance checks had been completed on the car, to ensure the person's seatbelt was secure and that the staff member with the person was first aid trained. This had been reviewed every three months and was signed by the person concerned to show their agreement.

Another person had a risk assessment in place for the safe use of knives. The assessment showed that the risk was regularly reviewed and measures had been reduced as the person's recognition and awareness of the dangers had increased. This showed that the service was proactive in monitoring and reducing risks to people so it did not compromise their right to live a full life. The registered manager told us "A lot of people can make informed choices, we can advise around risks and we explain the risks and what can happen. If we feel it is a risk we can put a risk assessment around it and inform the relevant people".

People were kept safe from the risk of emergencies in the service. A contingency plan was in place for people to be accommodated at the provider's other nearby services. A convent was next door to the building and the service had been told they could also use this to evacuate people to in an emergency. We saw an emergency sledge was situated at the top of the stairs to safely evacuate people who had mobility concerns in an emergency if they were unable to use the lift. Personal emergency evacuation forms were in place which detailed the support each person would require to safely leave the building in an emergency. A noticeboard in the reception area displayed guidance information for people to know how to respond in an emergency situation. A picture version of this was also displayed.

Environmental risks had also been assessed and maintenance staff recorded the checks completed on equipment, water outlets and fire safety checks. A fire drill had been completed prior to our inspection and we saw people and staff had signed to say they had been part of this and had evacuated the building safely.

When people had accidents, incidents or near misses these were recorded and risk assessments were updated or put in place if required. All events were reported to an accident reporting line which had a dedicated phone number. Staff were confident in the actions to take if someone had experienced an incident commenting "An incident report will be done, risk assessments, we inform manager, and ring the 'Near miss' number and explain the situation. They will advise on the phone. We ring 999 if an emergency" and "Raise the alarm, pull cord for help. This alerts other staff, contact 999, we are all first aid trained. We contact the manager and inform person's family".

The registered manager would investigate any incidents and reports to senior management. We saw that when accidents or incidents had occurred, a report detailing the nature of the incident and action taken was kept on the person's file.

There were sufficient staff to meet people's needs. The registered manager told us staffing numbers are increased depending on the type of activities people have planned to do. We looked at the staff rota which confirmed this and recorded people who needed support and what kind of support this was so staffing could be provided effectively. Staffing numbers were higher in the morning and evenings to support people in getting up and going to bed. In the daytime the majority of people living at the service were at college or at work so the staff numbers were reduced.

Staff felt they had enough time to spend with people and were not rushed commenting "There is enough staff, always enough to cover, we can spend time chatting with people", "There is enough staff, enough time to spend one to one time with people, and always staff around to help" and "We have got new staff starting, they are waiting for their DBS. We have more staff on when people are about and doing activities". A DBS is a Disclosure and Barring check to ensure they are suitable to work with vulnerable people. The registered manager said staff retention within the company was good and that "Senior management have never refused if extra staff have been needed". If extra cover was required the service used one agency to keep consistency and the deputy and registered manager were able to provide care if needed.

The registered manager explained how the provider's human resources department oversaw the

recruitment process and confirmed with them when information was obtained. This included references and enhanced background checks for prospective staff. The registered manager was able to request some of these documents during the inspection and they were immediately sent over for us to view. Staff files contained the questions they had been asked at interview. We saw that the same questions had been asked to applicants so that they applied the recruitment process fairly.

Peoples' medicines were managed and administered safely. At the time of our inspection staff were supporting two people with managing their medicines and everyone else self administered. Medicines were kept in a locked cupboard in people's flats and people had their own keys unless staff were supporting them with taking their medicines. Consent had been obtained to show that people were happy for staff to take responsibility for managing and administering their medicines. One person told us they were happy that staff gave them their medicines as "I would forget". Medicine dispensing forms were in place for people that spent time away from the service so the medicine could be safely signed out and taken with them.

We looked at the two people's medicine administration records (MAR) and saw that staff had signed correctly to show that people received their medicine. These were checked daily by management. Staff who administered medicines received a yearly competency based assessment to ensure their practice was safe and correct.

People's MAR's contained a photo of the person so staff could ensure the right medicine was going to the right person. Any allergies the person had were clearly listed and easy read information was available to help the person understand what medicine they were taking and why. We saw that the GP reviewed people's medicines regularly. Some people had been prescribed 'Medicine to take as required' (PRN). Protocols were in place for any PRN medicines which gave staff guidelines on when it was appropriate to offer this medicine and what it had been prescribed for. We saw when staff had administered PRN medicine the correct procedures had been followed, which included staff recording the reason why the medicine had been given on the back of the MAR.

We found the service to be clean. Staff were able to explain how standards of cleanliness were maintained and a cleaning schedule was in place to record that communal areas of the home were being cleaned. An infection control folder recorded information for staff on hazards, hand hygiene and the procedures for cleaning high risk infection areas. People were supported and encouraged by staff to clean their own flats and had responsibility for this.

Requires Improvement

Is the service effective?

Our findings

During our inspection we saw that for four members of staff their medicines training was not in date. When we spoke with the staff and registered manager there was confusion over if this had been one of the courses attended recently. One staff member did have a certificate of completing recent medicine training but had not been on the same course as the other members of staff. Another member of staff remembered doing it recently but could not remember the date or if they had received a certificate. The registered manager had recorded in her diary that training was happening over two days but was not sure who had attended this. The registered manager contacted the trainer to ask for an attendance record but the names of these staff were not listed. No certificates had been received by these staff. The online training system had not flagged this up to show staff were out of date for this training.

The registered manager immediately booked these remaining staff onto medicines training due to take place in October 2016 and showed us the booking for this. The registered manager then removed these staff members from administering any medicines until they had completed this training.

All other training had been completed by staff and refreshers had been taken where required. Training subjects included safeguarding vulnerable adults, fire, risk assessments and autism. Staff completed training face to face and online and most staff had completed or were working towards their Diploma in Health and Social Care. All staff had an electronic log in and could access their training records online and complete training during their working shifts.

New staff were supported to complete an induction programme before working on their own. They told us, "On my induction I did training and shadowed. I also met people living here", "On my induction I shadowed, it helped, I did more as I got more confident. I felt supported" and "On my induction I came in a few times to meet people, the maintenance staff showed me the fire procedures". The registered manager told us "The induction is three months, all mandatory training is done and staff shadow until their care certificate is completed and signed off. Staff receive an induction into the building and health and safety. They are shown the fire exits and meet all the other staff and people. They read the care plans and polices and procedures".

The majority of staff had received regular supervisions (one to one meeting) with their line manager. We saw one person who had not received their supervisions within the provider's stated timeframe. This person had not received a supervision since January 2016. The management team told us this would be addressed and they were in the process of arranging a date for this supervision to take place. Staff told us they found supervisions useful commenting "I can raise any concerns in supervisions", "Supervisions are useful" and "I work with the deputy manager a lot on the floor so she observes me working. My NVQ assessor has also listened and observed me".

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 legally authorised under the MCA. When people

are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

During our inspection we saw that some restrictions had been put in place to keep people safe. For example some people had their fridges locked in their flats as they could not control their food intake. Other people had their fuses removed from their cookers as were at risk of harm from not being able to safely operate them. Other people were under constant supervision by a staff member when they left the building to go out. We saw that risk assessments had been completed for these restrictions but there were not all these decisions were supported by mental capacity assessments or best interest decisions. For example for one person their care plan stated they were not free to leave, however there was no supporting paperwork to show this decision had been discussed and agreed by the appropriate governing body, which meant the home were restricting this person without the appropriate authorisation to do so.

We spoke with the registered manager about our findings who assured us that best interest meetings with health professionals had been held and the decisions taken from those. The registered manager took swift action in contacting people's social workers to request that the paperwork for these people be sent over. The registered manager told us she had not been provided with copies when these assessments had taken place and would address this going forward so that the service could evidence decisions had been taken appropriately and with the relevant professionals authorised to put restrictions in place. The registered manager was able during our inspection to source the necessary paperwork to show that people were not being deprived of their liberty without following the correct process.

The registered manager told us that people's social workers were responsible for making any applications or referrals to the appropriate governing body if people lacked the capacity to make decisions. The registered manager was not sure how far along in the process people's applications were and only had email correspondence in place to suggest that this was being arranged. We spoke on the telephone with one social worker during this inspection who informed us a professionals meeting had been held to discuss an application for one person, however the minutes of these had not yet been typed up. The registered manager told us this would be chased up with the social workers and copies of the applications made will be requested and kept in people's care plans so this can be tracked by the service as well. The registered manager told us "I want to get staff more clued up on MCA".

When we spoke with staff they demonstrated understanding around the principles of MCA and what it meant for people commenting "You can still offer choice, we try and keep them safe but people are entitled to take risks. We do things in their best interests", "Some tenants may need an assessment in place, not to take away their choices but for their safety", "We still give choice but we narrow the choices down so it doesn't confuse the person" and "Some people don't understand all the dangers so we support them and offer reduced choices".

Staff supported people who could become anxious and exhibit behaviours which may challenge others. We saw that staff had completed positive behaviour management breakaway training to aid them to effectively respond in these situations. Guidance was also available on prevention and de-escalation of events that may challenge. Staff were confident in handling these types of situations commenting "We use de-escalation, we try and encourage the person away from the area. I feel confident in these situations", "I have had training for behaviour that challenges. People's behaviour has calmed down a lot. We ensure other tenants safety, and ring the family and manager", "One person can start hitting out and swearing, we recognise the signs and try to distract the person. We have tried calming techniques, they are better with one member of staff than several. I feel confident to handle it, we find something different to do" and "One person's behaviour has significantly calmed down and the number of incidents has reduced".

We saw that any incidents were recorded so a person's behaviour could be monitored and assessed. The recording showed how each situation had been managed and provided techniques for staff to use that were individual to each person. Where necessary a behaviour therapist had been involved in helping the person understand positive behaviour expression. One person had a calming file in place which staff would use to sit with the person and go through pictures and words which suggested how to deal with behaviour that overwhelmed them.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. People had their own kitchens in their flats and would eat the majority of their meals in their flats. Staff supported some people in the planning, shopping and preparing of meals. One staff told us how they read out the cooking instructions to one person and help them to understand the timing different foods take to cook. Another staff member said they regularly check the dates on peoples refrigerated food and support them to throw items away if needed as one person has a visual impairment and needs assistance with this.

The service holds two communal meals a week so everyone can sit and eat together in the shared dining room. Staff told us people participate in the planning, shopping and cooking of this shared meal. People's comments included "I ask the staff for support if I need help", "The staff help me prepare my meals" and "I can cook myself but I also eat with the others as a family some day's, I like that it's nice". We saw for one person who used a wheelchair part of the communal kitchen had an area with lowered sinks, cupboards and a cooker so they were easily accessible for this person.

People planned their own meals but were encouraged by staff where possible to make healthy meal choices. For people needing support around nutrition we saw nutritional assessments had been put in place. The registered manager told us "We work closely with the dietician nurse and encourage healthy eating plans". We saw throughout our inspection staff were offering drinks or encouraging people to make their own to encourage hydration and daily living skills.

People's changing needs were monitored to make sure their health needs were responded to promptly. Health action plans were in place which recorded any medicines people were taking and health appointments attended. Goals that people had for their own health were documented and pictorial versions were seen in some care plans for people who preferred information in this way.

One relative said "I receive a phone call if my relative is unwell". One health professional told us "Staff either telephone or email to request a meeting to discuss service user's needs if necessary. Staff at Mayfield's take advice and instructions well. When a service user was staying away regularly at the family home and not using the support in place, we asked them to update their method of communicating this to both us and the person's educational placement to ensure that we knew within a set timeframe which they did and this worked well".

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments included "I like the staff they have helped me to be more confident and given me encouragement and support. I would not have had the confidence to speak to you before I came here", "I like the staff they are very friendly and helpful" and "The staff are friendly and always ask how I am and what I have been doing when I come home". We spoke with four relatives who all expressed they were happy with the care and support their loved one received from Maryfield staff.

Staff were knowledgeable about things people found difficult and how changes in daily routines affected them. We observed staff responding to people well and interactions demonstrated positive and trusting relationships had been built. One staff member told us "It's like being at home, it is so friendly and lovely to walk into". Another staff said "It's nice to see we have played a part in their life, and see that they are ready to move on".

People told us they had a keyworker. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. Staff comments included "As a keyworker I update the person's support plan and assist with shopping, finances and appointments", "I am a keyworker to two people and I support them to pay bills and other daily living skills".

People living at Maryfield had been encouraged to make and be involved in decisions about their care. Consent had been obtained for decisions such as 'The right for staff to enter their flat and assist with personal care', 'For staff to help with medicines' and 'Sharing a person's information with necessary other professionals'. These consent forms were signed and dated by the person and kept with their support plan. On arrival to Maryfield people had been given a service user guide which was available in different languages, large print, braille or an audio tape version. It stated that the vision was for all service users to be looked after with the upmost dignity and respect. It further provided information on the service's aims and objectives and the training and recruitment process staff had to complete to ensure they were of suitable character to be employed.

Peoples dignity was respected by staff. Staff comments around protecting privacy and dignity included "I shut the door, the curtains are shut so no one can look in. If someone is using the communal bathroom I make sure everyone knows not to go in", "Make sure the doors are closed, tell the person what you are doing. I encourage people to do things for themselves" and "I don't just enter people's flats, I wait for door to be answered". People had personal key cards or keypads to access their individual flats and were able to personalise their flats as they chose.

People were supported by the service to take responsibility over their daily activities commenting "I am encouraged to write a shopping list and go and buy my shopping and eat sensibly" and "They encourage me by asking if my room is tidy and this helps me to get motivated".

Staff told us that people were encouraged to be as independent as possible commenting "We support with

daily living skills, and slowly reduce the support to encourage independence. One person now makes their own shopping lists to plan out meals for the week", "We support out in the community. One person has started to pay their own bills with support, and their confidence has improved", "We promote independence, set goals and help them achieve" and "For one person we supervised in the community we have reduced this supervision now". The registered manager told us "Maryfield helps people transition from living with parents to moving on to independent living, it's a good opportunity".

Relatives we spoke with felt pleased life skills were being taught saying "My relative has become more independent" and "[X] speech has come on and they are more sociable now" and "My relative is better at making decisions and is more independent and more confident". One health visitor who regularly visits the service told us "Service user's are given various opportunities to develop their independence both within their support plan and as part of Mayfield's activities. Each person is supported to grow and develop their daily living skills and to maintain their independence both within Mayfield's and in the community. Personal care, cooking and cleaning on a daily basis along with integrating in clubs and the local community are all areas that the staff support each individual according to their needs".

We saw that people had 'Move on' plans in place, which the service supported them with to identify necessary strengths and goals to move towards independent living. Once a person was ready for this next stage the service would help source appropriate accommodation such as a shared housing. One person's care plan stated objectives the person wanted to achieve before moving into Maryfield, including budgeting and increased independence and we observed the person being supported in line with this.

The service had a proactive approach to respecting people's human rights and diversity and this prevents discrimination that may lead to psychological harm. Information about people's rights and equality and diversity were clearly displayed on noticeboards at the service. The registered manager explained "We treat everyone fairly, and see how potential staff come across. It's not just about their interview answers and it's not what we want, it's what the tenant wants. We have a mix of staff and people at Maryfield, people have to learn to be accepting of the way culture changes. It doesn't bother me how people live their life as long as they do their job well".

Requires Improvement

Is the service responsive?

Our findings

We saw that at times support plans had not always been fully completed. For example one key worker record that we viewed stated a goal that the person was working towards with the support of their keyworker. However no agreed actions had been completed for this goal and there was no date or signature on this form to know when it had been put in place or if progress had been made.

One person had an assessment in place for the use of bedrails. This document did not record the final decision that had been made or any comments or input from the person, or if they had declined to comment. We raised this with the registered manager who ensured that the document was completed during our inspection. The registered manager further told us this would be addressed with staff and recorded in the handover communication book.

We saw that some of the terminology used in people's support plans was not appropriate. For example when describing people's behaviour the word 'silly' was used several times.

One person had a reward chart in place that was referred to in the support plan. The plan stated that if 'the person had been good' they would be rewarded with a treat they favoured, however if their behaviour had not been good they would lose something they valued for a period of time. We spoke with the registered manager about staff understanding of depriving a person of their personal belongings as a result of not reaching the target behaviour portrayed on the chart. The registered manager explained this had been put in place by the person's relative and was not something the service were using or following. The registered manager said the support plan would be amended to reflect this.

For people that were assisted with having a bath in the communal bathroom there was no temperature monitoring sheet in place for staff to record temperatures of the water to ensure it was suitable for people. The registered manager said staff would always check but this had not been documented and a recording sheet would be put in place.

People or their relatives were involved in developing their care, support and treatment plans. Support plans were personalised and detailed daily routines specific to each person. People had signed their support plan to say they had read it and were was happy with the information recorded. Support plans contained information on people's life history, their likes and dislikes and who and what was important to them. The plans were also in pictorial format showing how to meet the individual's needs and what daily activities the person was involved in. A health professional told us "The staff do get to know the service user's well and know their likes and dislikes and play an important part in their life based on trust and good support".

We saw that care plans were reflective of the key areas a person required support in such as mobility, access to activities and making or attending health appointments. Information recorded was specific to the individual and stated who would take responsibility for supporting the person in that role. One staff member told us "The social workers give us a support plan of the person when they come, but I always speak to the person and see what they like to do. We get time to read care plans because we need to know about

everyone".

People's needs were reviewed regularly and as required. Where necessary the health and social care professionals were involved. A review agenda was in place in people's support plans which had asked them who they would like to be present at their review and what they would like to discuss. We saw for one person it recorded the different health professional who had been part of the review, including a social worker, dietician and community nurse.

Staff told us "People have four reviews, one after a week when they move in, then at six weeks, six months and then they go to yearly", "Staff are informed as we attend the reviews if we are the person's keyworker". One person living at Maryfield said "The staff always ask if I am ok and if there is anything else I need to do or talk about". A keyworker record showed discussions had taken place asking if people were happy with the support they received and what they would like to progress with. One question had also asked if people felt involved with what goes on at Maryfield. People's support plans were reviewed monthly and a review chart was in place which stated if any updates had been added.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. We reviewed the daily recording and saw that staff wrote about people as individuals and in meaningful ways capturing what each person had achieved that particular day. A communication book was also in place for staff coming on shift to read. One staff told us "We have a full handover, there is good communication".

People were supported to follow their interests and take part in social activities, education and work opportunities. One person we spoke with was preparing for an internship at Uplands Educational Trust (UET) college. Another person showed us their planner of activities and things to be done daily, which they were kept on their mobile phone so they knew the time and date of things planed.

Group activities were also planned alongside individual interests and people could write their name on a poster if they wanted to participate. Previous group activities had included trips to the seaside, zoo, parties for people's birthday's and a summer prom. Staff commented "There is a club every week called the 'Happy Maryfield club' and someone from UET comes in and does cooking or arts and crafts with people", "On Monday's it's people's choice what they want to do, some group activities are planned the zoo and seaside during holidays as most are at school normally" and "People have allocated hours and will tell us what they want to do and this feeds into the plan".

The service had good links with the local community. Staff were proactive and made sure that people were able to maintain relationships that matter to them. The service worked in partnership with Uplands Educational Trust (UET) the school people attended. The school also taught and ran activities on site bringing more people from the community into the service. One person told us "I have lots of friends here, I knew some of them before from school". Another person commented "I go on the bus on my own to my mums and college". The registered manager commented "As a new home we introduced people from Maryfield to the local pub, coffee shop, and shop so they are known in the area".

People had been made aware of the complaints process and a system was in place to manage any concerns raised. A complaints folder offered guidance for staff on processing any complaints received. The service had received no complaints at the time of our inspection. Information about the complaints process and contact details was contained in the service user guide and an easy read version of the complaints process was available on the noticeboard for people to view.

One staff member said "If someone has a concern we will sit and discuss it and find a way they are happy with and inform the manager". Informal concerns were also logged and dealt with as they arose. One relative told us "Any niggles I have, I just tell the key worker and it's sorted, only been small stuff of no concern".

People's experience of care was monitored through a feedback survey sent by the company annually. Maryfield also gave people a service survey six monthly to gain feedback at a local level. The registered manager would make the results of the survey available for people to view. A comments and suggestions book was kept on the front desk and staff encouraged people to make any suggestions about the service known. A suggestion box was also available in the entrance hall if people wanted to give feedback anonymously.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we saw that not all reportable incidents about significant events had been notified to The Care Quality Commission (CQC). This information is used to monitor the service and ensure they responded appropriately to keep people safe. Notifications that had not been received included incidents with police involvement and events that stop the service from running as it should. Some of these incidents had been raised with safeguarding and the service had managed these events internally. We saw a safeguarding checklist in place which stated that management had to notify CQC as part of the process. The provider policy for these events also stated that the relevant CQC statutory notifications must be completed. This had not been done.

We spoke with the registered manager about what must be reported to CQC. The registered manager told us this was a learning curve, and they had not previously been aware of everything that needed to be submitted or if these notifications had been made at a higher level after sending a report to senior management. The registered manager said that this would be discussed with all the staff so they were aware of what was reportable in going forward.

This was a breach of Regulation 18 (2) (f) Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

A registered manager was in place at the service who had a long background of experience in the health and social care sector. The registered manager spoke passionately about what they were trying to provide at Maryfield and the individual achievements people had been supported to reach. The registered manager told us "I feel as a manager I have done my best and I hope to get better, and hope more schemes like Maryfield develop. There is good morale in the staff team, the deputy and staff have done a fantastic job".

People and their relatives knew the registered manager and staff team well and spoke positively about the leadership of the service, commenting how they were always informed of any
Events and kept up to date. One health professional commented "They are very friendly and amiable staff, easy to speak with and prompt to respond to any concerns raised to the best of their ability. Management have always been very helpful to me".

Staff told us they had been supported by the management team. Comments included "No problems in approaching managers, I am happy to speak to my manager. The area manager comes in and speaks to people and staff too", "The manager is always around, we can ring her anytime, she's approachable and supportive", "Management are visible on the floor, we can go to them with anything", "Managers are available to ring anytime" and "We did have staff meetings regularly but we are a small base, so we are always talking regularly. We always have a meeting if a new person is moving in". The registered manager told us about one staff member who had been supported to take on a different role when their health declined rather than have to leave employment with the service.

The service has a positive culture that is person-centred, open, inclusive and empowering. People had been

given a copy of the service's statement of purpose which set out the objectives they wanted to achieve for people. This stated that the 'Service will work to encourage and support people to reach their full potential'. Staff felt the values of the service were well represented commenting "The values of the service promote independence and give people the chance to live life in the way they want" and "The service is good in helping people live independently and move on, it's nice to see their confidence grow". We saw that staff were able to access the provider policies online or in a hard copy format to ensure they understood their responsibilities.

People were empowered to contribute to improve the service and were kept informed of events happening within the service. A folder was in place in reception which recorded information about events and activities that were taking place, or any news that involved Maryfield so people could be kept informed. Tenant meetings had been held regularly and we reviewed the minutes of some of these meetings. We saw a recent meeting had discussed an upcoming trip, the types of meals people wanted at the communal meals held twice a week. Staffing was discussed and people were asked if they were happy. People had been encouraged to elect a house representative to gather people's voices but no one had chosen to take this up at present. A questionnaire had been given to people to ask what they thought of the house meetings. We saw that the majority of people had recorded they wanted these to continue, as they were a good opportunity to discuss events relating to Maryfield.

Quality assurance systems were in place to monitor the quality of service being delivered. Monthly audits were completed which looked at medicines, infection control and incidents or accidents. This information was collated at a higher level and in the service people were monitored on an individual basis. The registered manager told us it would be useful to also start collating this at service level so they could identify any trends, and this started to be put in place during our inspection. The area manager would come to the service monthly and complete an overall audit, and the registered manager told us managers complete audits at each other's services to identify any areas requiring improvement.

The registered manager was supported in their role by a deputy manager and senior management who made regular visits to the service. The registered manager told us "I have manager meetings monthly and one to one supervisions with my manager regularly. I have brilliant support, from my manager and the area manager. Sanctuary are good at support". The registered manager was also able to take part in opportunities within the company and was part of a group that looked at the support and risk planning paperwork within Sanctuary.

The service worked in partnership with many different health and social care professionals such as social workers and occupational therapists and each person had their own team of support. The registered manager spoke about the partnership the service had with the college commenting "We have worked hard at this new scheme, and worked well with the school for transitions, with the teachers and trustees. This partnership is unique. We also have good relationships with the Local Authority who provide assistance to us".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Not all reportable incidents about significant events had been notified to The Care Quality Commission. Notifications that had not been received included incidents with police involvement and events that stop the service from running as it should. Regulation 18 (2) (f)