Consensus (2013) Limited

Cheshire House

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

This inspection took place on the 4 and 6 April 2017. The first day of the inspection was unannounced.

The service is registered as a care home providing nursing care for up to eight people with a learning disability and /or associated mental health need. Each person has their own self-contained flat and receives one to one support depending on their assessed need. At the time of our inspection there were five people living at the home. The service supported people with complex care needs and associated behavioural issues.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also a registered mental health nurse. They were supported by a registered learning disability nurse.

The service was previously inspected in March 2016 where we found three breaches of the Health and Social Care Act 2008 in relation to assessing and mitigating risks, obtaining people's consent for their care and treatment and staff training. At this inspection we found improvements had been made in all three areas.

People we spoke with and professionals involved with the service were complimentary about the care and support provided by Cheshire House. People said they felt safe and that the staff knew their needs a well. The staff we spoke with showed they had a good understanding of people's needs. There were sufficient staff on duty to meet people's needs.

Care plans, risk assessments and positive behavioural plans were in place. Clear guidance was provided for staff to support people and mitigate the identified risks. The service worked closely with the community learning disability team (CLDT) to support people manager their behaviours. The care plans promoted people's independence where appropriate and were evaluated regularly. Staff knew the guidance in place to support each person safely.

Incidents were analysed and de-briefs were held with the staff team, the provider's behavioural specialist and the CLDT to learn from each incident. The behavioural support plans were updated as required following an incident.

Staff had received suitable training for them to undertake their role. This included specialist training in areas such as mental health and personality disorder. Staff had completed training in safeguarding vulnerable adults and explained the types of abuse and the action they would take if the witnessed or suspected any abuse had taken place. New staff received a comprehensive induction to the service and people's needs.

Staff received regular supervisions from the team leaders. The registered manager supervised the team

leaders. Regular team meetings were also held. Staff told us these were open forums where they were encouraged to contribute to the discussions and raise any ideas or concerns.

Staff said they felt well supported by the registered manager and behavioural specialist. They were positive about the changes in the management structure and the introduction of key workers. They said they were now more involved in developing people's care and support and liked the increase in responsibilities.

A robust procedure was in place for assessing people referred to the service. The registered manager and behavioural specialist completed an initial assessment and were able to state if the person could or could not be supported by the service. Staff were also involved in visiting people before they moved to the service so they could get to know them and their needs.

During the inspection we observed and heard kind and respectful interactions between the people who used the service and the staff team. People told us they liked the staff who supported them. People were supported to plan activities each week. Staff were matched with people so they engaged in the planned activity, for example aqua aerobics, with the person they were supporting.

Medicines were administered as prescribed and stored safely. Staff had received training in the administration of medicines. We checked the quantities of medicines stored at the service corresponded with the medicines administration record. We found two 'as required' medicines were correct but one was not. We saw weekly audits and counts of medicines were completed which would have identified this issue. We saw any issues were actioned by the nurse.

Health action plans were in place for each person. We saw people were supported to maintain their health and wellbeing.

We found the service was working within the principles of the Mental Capacity Act (2005). Capacity assessments and best interest decisions were made where required. Applications for Deprivation of Liberty Safeguards (DoLS) were appropriately made. Staff offered people day to day choices about their care and sought their consent before providing support.

The home was seen to be clean. Cleaning schedules were in place but were not always fully completed. Infection control audits were completed to monitor the home.

Systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and gas supply. Regular checks were in place of fire systems and equipment.

Surveys were completed to gain feedback about the service from people, their families and staff.
A complaints procedure was in place. People we spoke with said the staff and registered manager dealt with any issues they raised verbally without needing to use the formal complaints process. This was confirmed by the staff and registered manager.

We noted there were a number of quality audits in the service; these included medicines, care records, accidents and incidents and health and safety checks. The Operations Manager also completed a monthly visit and audit. We saw actions were identified from the audit and were then completed.

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.

Risk assessments and comprehensive behavioural support plans were in place to mitigate the identified risks.

Incidents were analysed and staff were de-briefed to identify any patterns and changes in support required to reduce the likelihood of the incident re-occurring.

Medicines were administered as prescribed. 'As required' medicine guidelines were in place. Any errors were identified through weekly audits and a medicines concern form. Action was taken to remedy them.

People felt safe and staff had received training in safeguarding adults and knew the correct action to take should they witness or suspect abuse.

Is the service effective?

Good

The service was effective.

Systems were in place to assess people's capacity to consent to their care and treatment. Applications were made for a Deprivation of Liberty Safeguards (DoLS) where appropriate and staff were knowledgeable about the requirements of the Mental Capacity Act (MCA).

Staff received appropriate training, including specialist training, to meet the needs of the people living at Cheshire House.

The service liaised with health services and the Community Learning Disability Team as required to maintain people's physical and mental health.

Is the service caring?

Good

The service was caring.

We saw and heard respectful interactions between people and staff throughout our inspection.

Information about people's life histories, likes and dislikes was sought. Staff knew people well.

People were involved in planning their goals and support. People were supported to increase their independence.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place which contained information and guidelines for the staff to be able to meet people's social care and support needs.

People were supported to engage in a range of activities that they chose.

A robust assessment procedure was in place for people referred to the service. Staff members were involved in meeting the person and shadowing their existing staff team to get to know the person before they moved.

Is the service well-led?

Good

The service was well led.

There were a number of quality assurance processes in place. These were used to help monitor and improve the service.

A registered manager was in place as required by the service's registration with CQC.

Staff told us they enjoyed working in the service and were more engaged in developing the care and support plans for the people who used the service.

The provider had systems in place for gathering the views of the people who used the service, their relatives, other professionals and staff.

Cheshire House

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 the 4 and 6 April 2017. The first day was unannounced. The inspection was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.
We contacted the local authority commissioning and safeguarding teams, the community learning disability team as well as the local Healthwatch board. No one raised any concerns about Cheshire House.

During the inspection we observed interactions between staff and people who used the service. We spoke with four people, the registered manager, the registered nurse, the provider's behavioural specialist and seven staff members. We looked at records relating to the service, including four care records, four staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at Cheshire House. One person said, "I can sit in my flat with staff and I feel safe." Another told us, "I like being in my new flat; it's quieter so I feel safe."

We saw that suitable arrangements were in place to help safeguard people who used the service from abuse. The training records we saw showed that staff had undertaken training in safeguarding vulnerable adults. The staff members we spoke with confirmed this and were able to explain the correct action they would take if they witnessed or suspected any abuse taking place. They told us that they would inform a team leader or the registered manager. We saw the service had appropriate safeguarding and whistleblowing policies in place to support the staff in providing safe care. We saw one person who used the service was supported to report a concern after another person supported by the service had been verbally aggressive towards them. This should help ensure that the people who used the service were protected from abuse.

At the last inspection in March 2016 we found that the provider had not clearly assessed the risks to the health and safety of service users or ensured staff had the information they needed to mitigate such risks. At this inspection we saw improvements had been made.

We saw risk assessments were in place for each person, for example road safety, finances and manual handling. The assessments gave clear guidance for staff to manage potential risks. Guidance for staff was easily accessible on the notice board in the staff office for two serious potential risks. Contingency plans were also in place if a person went out on their own and did not return at the agreed time. This meant staff had the information they needed to mitigate the identified risks and how to respond if people's actions put them at risk of harm.

The behavioural specialist visited Cheshire House each week and had developed clear behavioural support plans. These identified potential triggers for any behaviour the service may find challenging and how staff should support the person to reduce the risk of harm to themselves, other people and the staff. The plans detailed strategies to use to de-escalate incidents and specified whether physical restraint was appropriate for each person. If physical restraint was appropriate the plan gave guidance on when to use it and what restraint holds were to be used to ensure people were kept safe. We saw physical restraint was to be used to maintain the person's safety and protect the other people living at the service. Its usage was minimised and only appropriate if all other strategies had not worked. The behavioural plans also clearly stated when the use of physical restraint was not appropriate, for example we noted for one person restraint was not to be used as it increased the person's aggression rather than de-escalated the situation.

A separate file had been created for each person for the behavioural support plans and any other associated information provided by the behavioural specialist. A copy of the behavioural support plan was also included in the person's care file. We discussed how the team ensured the information in the care files was current with the registered manager and behavioural specialist. They explained the team leaders received an email copy of any updated information and plans from the behavioural specialist and they printed these

off and included them in the care file. The registered manager said they would only use the behavioural support file in future and remove the behavioural plans from the care files. This would ensure all available information would be current and up to date and reduce duplication.

We saw that incidents were recorded, with antecedent, behaviour, consequence (ABC) forms were used to detail potential triggers to the incident, what happened during and after the incident. These were detailed and recorded the times of the incident, the person's behaviour and staff support and actions. Staff told us a de-briefing was held after each incident, involving the behavioural specialist, to support each other and to look at if any changes in how the staff supported the person could potentially reduce the risk of the incident re-occurring in future. The positive behaviour plans were updated if required following an incident and the staff de-briefing. The community learning disability team were also notified of any incidents and were involved in reviewing the behavioural support plans with the staff team when appropriate. The behavioural specialist also spoke with the person who used the service about the incident and what they could change in the future to reduce their own anxieties. Staff told us they felt well supported by the registered manager and behavioural specialist when managing any incidents of challenging behaviour.

One staff member said, "We're more confident in supporting people now, in our own ability and there is always someone available to back you up." We saw feedback to an incident had been given by the community learning disability team. This noted 'the compassion, resilience, commitment and skill of the support workers' in managing an incident.

We saw one person had moved to a different flat within the building since our last inspection. From analysing incidents with this person it had been found one of the main triggers for the behaviour was interaction with other people living at the service. They had moved to a different part of the building which was separate from the other people. The flat was therefore quieter and interaction with other people reduced. This had led to a reduction in the number of incidents involving this person. A staff member told us, "[Name] has done really well with a structured week and the move to their new flat."

This meant the staff team had the appropriate training and information to support people to manage their behaviours. Staff told us their confidence in supporting people when incidents occurred had increased since our last inspection.

All the staff we spoke with felt there was enough staff on duty to meet people's needs. We saw one staff member was allocated to work with each individual. There was also a team leader or registered nurse on duty to provide additional support if required. Rotas we saw showed the number of staff on duty was consistent.

We looked at the recruitment files for four members of staff. We found they all contained application forms detailing previous employment histories, notes from the interview, two references from previous employers and showed appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. Where applicable checks had been made with the Nursing and Midwifery Council to ensure nurses were registered with them. A new member of staff told us the recruitment process had been thorough, including two interviews. This meant the people who used the service were protected from the risks of unsuitable staff being recruited.

As part of our inspection we looked at whether medicines were being administered, stored and disposed of safely. We saw an up to date medicines policy was in place. Training records showed, and staff confirmed, that staff had received training in the administration of medicines. We saw evidence that observations of the senior staff members administrating medicines had been completed. This meant the staff were provided

with the skills and knowledge to administer medicines safely.

People's medicines were stored in their own flats in a secure cabinet. Two members of staff administered the medicines and signed the Medicine Administration Record (MAR). We looked at two people's MAR charts and saw they had been fully completed. This showed they had received their medicines as prescribed.

We checked the quantities of three medicines and found two were correct, however one medicine had one less tablet in the box than indicated by the recorded quantity administered on the MAR. The medicine in question was prescribed as a variable dose of one or two tablets.

The service audited the medicines each week, including a full count of any boxed tablets. The discrepancy we found during the inspection would have been noted at the next weekly inspection. We spoke with the registered nurse about this who said they were going to undertake a review of the medicines to try to establish the cause of the discrepancy.

We noted that each person's medicines file contained a 'medicines concerns form'. This recorded any issues with the MAR sheet, for example missing signatures. We were told that any concerns were followed up by the registered nurse and discussed with the staff on duty at the relevant time, for example when the signature was missed.

Guidance was in place for any prescribed creams detailing when they were to be used and where they needed to be applied. This meant people received their medicines as prescribed.

Procedures were in place for when people visited their families and needed to take their medicines with them.

We saw guidelines were in place for some 'as required' medicines, such as pain relief. However we noted one person had been prescribed two new as required pain relief medicines which did not have any guidelines in place. We raised this with the registered nurse who told us this had been highlighted at a recent internal audit and the guidelines were being written. We were subsequently shown the new guidelines. The team leader we spoke with told us the person was able to inform them if they required any pain relief. We observed that another person was asked if they needed an 'as required' medicine and were able to clearly state if they did or not. For completeness this should also be recorded in their medicines file.

This meant the service audited the medicines administered and took action where any issues were found.

At the time of our inspection the service did not administer any controlled drugs. A cabinet and controlled drugs register was available in the office if any person supported by the service was prescribed a controlled drug.

The home was clean and well maintained. An internal infection control audit had been completed in March 2017 and areas for improvement were noted. Cleaning schedules were in place, however we saw they had not always been signed as completed by staff. Adaptations to bannister rails on the stairs had been made to reduce the risks of people falling or climbing over them. We saw cleaning schedules were in place for staff to follow. These had also been discussed with staff at recent team meetings to ensure they were followed.

We checked the systems that were in place to protect people in the event of an emergency. We found personal emergency evacuation plans (PEEPs) were in place for people who used the service. These plans detailed people's mobility needs and understanding of a possible emergency situation. An emergency

business plan was in place with contact information and guidance for staff to deal with any emergency situations such as a gas or water leak, heating failure or evacuation of the building.

Records showed the equipment within the home had been serviced and maintained in accordance with the manufacturer's instructions. We saw weekly and monthly tests were completed for the fire alarm and emergency lighting system, however we did see that four weeks had been missed in the three months December 2016 to February 2017. There had been no missed weeks since February. A fire risk assessment had been completed by an external company in August 2016. All recommendations made had been completed. Fire drills were undertaken every three months. This should help to ensure that people were kept safe.

Good

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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 on authorisations to deprive a person of their liberty were being met.

At the last inspection we found a breach in the regulations due to information in relation to restrictions placed on people and why decisions to impose restrictions had been reached were not always clear. At this inspection we found improvements had been made.

We found staff had received training in MCA / DoLs and were able to explain why restrictions currently in place were required, for example one person always had staff support when they accessed their local community. Staff were also able to identify people who were not subject to a DoLS as they were able to leave the service on their own. One person could access a side gate to exit the home and knew the code to open it.

We saw DoLS applications had been appropriately made and any conditions were being followed. For example one DoLS authorisation stated that the person required an Independent Mental Capacity Advocate (IMCA). A referral had been made for an IMCA who had visited the person. We saw evidence that any additional restrictions, for example staff holding one person's cigarettes on their behalf, had been discussed and agreed with them before an additional DoLS application had been made for this new restriction. This had resulted in the person not running out of cigarettes and so reduced their anxiety.

Where people may lack capacity to make a decision a best interest meeting should be held with the relevant people to establish what is in the best interests of the person. We saw a best interest decision had been made for one person who wanted to go on holiday with staff support. This outlined the decision to be made, the benefits of going on the holiday and the potential risks involved. Plans were put in place to mitigate the identified risks. This meant the service followed the principles of the MCA.

As previously mentioned in this report behaviour support plans were in place which provided guidance on any physical intervention (PI) that may be appropriate. We saw best interest meetings had been held to discuss and agree on the need for PI for each person. The registered manager, behavioural specialist and the staff team were all able to explain the situations where they would use PI and where they would not. Staff clearly told us how PI was only used to ensure people's safety and to remove them away from a

situation to enable them to reduce their anxieties. They were also clear that PI was not appropriate for one person who used the service as it resulted in an escalation in the person's behaviour rather than minimising it. The PI to be used was detailed in the behavioural support plan and all staff received training in the PI techniques used by the service, called Maybo conflict management. One staff member told us, "We don't use restraint very often; we use de-escalation techniques and have built better relationships with people so we are more confident when we support people."

At the last inspection we found staff had not completed specialist training to support the people who used the service and had concerns about the skills mix of the staff team as the registered nurses were learning disability nurses rather than mental health nurses. At this inspection we found improvements had been made.

The registered manager was a registered mental health nurse and another registered learning disability nurse was also employed by the service. This meant the staff team were able to support people with their mental health needs.

Records showed, and staff confirmed that they had completed a range of mandatory courses such as health and safety, infection control, fire safety, food hygiene, nutrition and first aid. In addition staff had completed training in more specialised areas, for example PI training, advanced mental health and personality disorders. Team leaders had been offered courses on the principles of team leadership. We were told these additional courses had helped them settle into their new role.

Staff who joined the service completed an induction period where they completed their training, read people's care files and shadowed experienced staff to get to know the people who used the service. A new member of staff said, "I hone in on people's likes and dislikes in their care files so I can start to build a relationship with them." Staff who were new to care were enrolled on the care certificate. The care certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. We also saw that staff had completed, or been enrolled on, national vocational qualifications in health and social care.

We spoke with one staff member who was returning to work after an extended period off work. They were supernumery to the rota for two weeks to enable them to re-read all the care plans and shadow experienced staff to re-introduce themselves to the people they would be supporting. This meant staff were provided with the training and knowledge to undertake their role.

The registered manager had delegated the arranging and monitoring of staff training to one of the team leaders. Their role was to ensure staff were completing any refresher training courses required and organised any additional training identified. This meant there was more oversight of staff training requirements and the staff should receive the training they needed to support people appropriately.

We saw team leaders were now completing staff supervisions, with the registered manager supervising the team leaders and nurse. Staff told us the supervisions were open discussions and they were able to raise any ideas or concerns with the team leaders. Staff had received training in how to conduct supervisions. All the staff we spoke with said they felt well supported by the team leaders and registered manager. This meant the staff team received the support to complete their roles.

Handovers were held between each shift to inform the incoming staff about the wellbeing of each person and any changes that had been noted. Staff told us that if they had been off for a period of time, for example on annual leave, they would ask for an extended handover to ensure they were up to date with anyone's

changing needs. A handover form was used to ensure all monies held by the service had been checked, the staff allocation for the shift was recorded and a note made of any as required medicines administered.

We saw people were supported to complete their own shopping, including ordering the food on-line and then going to the supermarket to collect it. People were supported to prepare and cook the meals they wanted. Staff prompted people to choose a healthy balance of meals where possible. People were weighed each month; at the time of our inspection there were no concerns about people being under weight. This meant people were supported to meet their nutritional needs.

People who used the service had a health action plan in place. All the people who used the service were registered with a local GP. We saw medical appointments were made where appropriate. Some people attended appointments with staff support and others on their own. We saw care plans were in place to support people who may become anxious when attending medical appointments.

The service also had good links with the community learning disability team (CLDT). The professional we spoke with was positive about the service and the support provided. They commented that they had worked closely with the service and seen improvements in the support provided by the staff team. They said the team were very consistent in their approach and had been able to prevent people having to be re-admitted to hospital on several occasions. The service reported all incidents to the CLDT. They said that because of the improvements made by the service they no longer have to be as involved as they were.

This meant people's physical and mental health needs were being met by the service.

Good

Is the service caring?

Our findings

All the people we spoke with were positive about the staff supporting them at Cheshire House. One person said, "The staff are really great; I really like living here."

People lived in their own flats at the service, therefore our observations of interactions between people and staff were limited. Those that we did see were all positive, with interactions being respectful. People were comfortable with the staff supporting them.

Throughout the inspection we were able to hear people talking with staff. These conversations were meaningful and where appropriate humorous. We heard and saw staff knocking on people's doors and asking their consent before carrying out any support tasks. For example we observed one person discussing what they wanted to buy from the supermarket. The staff member spent time prompting the person which enabled the person to make a decision about what they needed and how they would budget their money so they could participate in other activities they wanted to do as well as buy the items they wanted.

Staff were able to clearly explain how they maintained people's privacy and dignity. People were supported on a 1:1 basis and staff said they would leave people's flats if they were making a phone call or bathing. One person confirmed this and said, "I can say when I want time on my own and the staff will leave me and then pop in and check I am okay."

People's flats were personalised. One person said, "I chose what colour I wanted the flat painted before I moved in." Another person had a pet which they were supported to look after. They also had access to the back garden and had a greenhouse and hanging baskets where they grew plants and vegetables.

This meant staff respected people's privacy and dignity when supporting them.

The care files we looked at contained information about people's life histories and details of their likes and dislikes. Staff knew people well and were able to explain their preferences.

We were shown a new person centred planning computer system the provider had developed. This was starting to be used to engage people in establishing what they like to do, what their current skills are, what activities they would like to try in the future and what their goals are. For example one person said their goal was to live in their own house with staff support. From this an action plan could be agreed for what the person needs to do to achieve their goal and what support they will need. The computer programme included photographs and written descriptions to enable people to be able to understand and be involved in completing it. This meant the service was involving people in developing their own care plans and activities.

We saw care plans had been written to support people to increase their independence. For example one person wanted to access the local area on their own. A plan had been devised where by staff would initially shadow the person when they went out to known locations. The aim was that the staff would shadow the

person at an increasing distance to ensure they were safe before the person went out on their own. This meant the service was supporting people to increase their independence in a supportive environment.

The service supports adults with mental health issues. At the time of our inspection all the people living at the service were healthy. We spoke to the registered manager about end of life care plans. We were told training in end of life care was currently being agreed by the provider. If any health issues were identified through the regular health checks people had staff would discuss their wishes for their care and support with them and their families where appropriate.

We saw all care files and staff records were kept in the staff office, which was locked. Medicine Administration Records (MAR) were kept in people's own flats. This meant people's confidential information was securely stored.

Good

Is the service responsive?

Our findings

At the last inspection the care files contained a lot of historical information. At this inspection we found the care files had been organised and historical information removed. Information was no longer duplicated. This meant that relevant information was easier for staff to access.

The registered manager told us they completed all assessments for new people referred to the service with the behavioural specialist. They were then able to recommend if the person was suitable to move to the service. Consideration was given during the assessment process to ensure they would be compatible with the people currently living at the service. We were told the provider did not pressure the registered manager to accept a new person who they did not think the service would be able to support. This was confirmed by the behavioural specialist we spoke with.

Before a person moved to the service the staff team would visit their current support placement to meet them and shadow their existing staff. Where applicable specific training would be arranged given by the current support service. For example one person used dialectical behavior therapy (DBT) to support them to manage their emotions. Staff had received training in DBT from the person's old support service before they moved to Cheshire House. We spoke with staff who were in the process of visiting one person who was due to move to the service. Where appropriate people also visited the service over a period of time before they moved in.

After a person had moved to the service the staff were able to contact the previous care provision to discuss the person's support and ask for advice if needed.

This meant the service had a robust procedure for new people moving to the service to ensure they could meet their needs and provide a planned transition for the person moving to Cheshire house.

We reviewed four care plans and saw they included personalised guidance for people's social care needs and support. For example care plans were in pace for communication, personal care, community access, finances and what staff needed to do if someone went missing. The care plans also included information about people's mental health and indications for staff to look for which may indicate that a person's mental health was deteriorating and what support they needed to provide. The care plans were evaluated each month to ensure they continued to reflect people's needs.

The social worker and community learning disability team we spoke with told us the service kept them informed of any changes in people's needs and regular reviews took place. They said, "[Registered Manager] reports all incidents so we can be part of the debrief with the team. The service collaborates well with us.

The behavioural specialist completed social stories with people to support them to manage their own behaviour. For example one person did not like having to follow rules. A social story was completed with them to discuss why there are rules and what happens if people don't follow the rules. They were then able to agree a set of rules for the person; for example not playing their music very loudly as other people can

hear it in their flats.

This meant the staff had the information to meet people's needs.

We noted that people's goals in their care plans were not up to date, for example one person's was dated January 2016. However staff and the registered manager knew what each person's goals were. For example we were told how one person wanted to move and live in their own flat and another wanted to travel on the tram by themselves. Two people we spoke with told us about their goals and that they had discussed them with the staff team. As mentioned previously in this report a new computer based person centred planning programme was being introduced which involved people developing their goals and wishes. This identified the skills people needed to have to achieve their goals and how they were to be supported to gain them. This meant people's goals were discussed, identified and known by the staff team but were not always recorded in people's care files.

People we spoke with said they were able to participate in the activities of their choice. We saw one person's care plan had identified the person needed to have regular activities and things to do in order to reduce their anxiety levels. Each person planned their timetable of activities for the following week with staff at the weekend. We saw a white board was used in the staff room to identify what each person was due to do that day and which staff member was allocated to support them. We saw one person was supported to undertake a voluntary work placement and another person went out on a train trip of their choice each week and to the local gym.

We were told staff skills were matched with people's activities so that the staff were able to engage in the activities with people. For example one person enjoyed aqua aerobics. Staff were matched for this activity so they did the aqua aerobics session themselves with the person. This meant people were supported and encouraged to participate in activities by staff who would get involved in the activity.

We noted one person was reluctant to go out at the time of our inspection. Staff explained how they planned things to do with this person and encouraged them to do them, however they often refused. People's weekly timetables also indicated time the person wished to stay in and watch TV. This meant people were supported to plan what they wanted to do each week and encouraged to take part in the planned activities.

The service had a complaints policy in place. We noted there had not been any formal complaints since our last inspection. The registered manager told us they and the staff team responded to any issues when they were raised with them which meant issues were dealt with before they escalated to the formal complaints procedure.

Good

Is the service well-led?

Our findings

The service had a registered manager in post, who was also a registered mental health nurse, as required by their registration with the Care Quality Commission (CQC). They had previously been the deputy manager and had been promoted in January 2017. Interviews were taking the place the week of our inspection for a deputy manager. A registered learning disability nurse was also employed by the service. The provider employed a behavioural specialist who visited the service each week. They developed and reviewed the behavioural support plans and were involved in the staff de-briefs following an incident.

The staff team had been re-organised in July 2016 to create four team leader positions. The staff we spoke with were positive about this. We saw the team leader role had been reviewed with them when the registered manager had been appointed. The registered manager had then delegated roles to the team leaders, for example organising training and ensuring the rota was covered. The team leaders also completed supervisions for a small number of named staff.

Each person had been allocated two keyworkers. The keyworkers role was to meet people monthly to discuss their support and to ensure people's care files were reviewed and up to date and lead on supporting the person to plan their activities and appointments where required. For example one member of staff told us they had contacted the occupational therapist to assess the person for a bath seat to enable them to get in and out of the bath safely. Staff told us they enjoyed this added responsibility. One staff member told us, "People can ask me something and I can deal with things now instead of having to refer to the nurses." Team leaders and staff members said they were now more involved in people's care and support and felt well supported by the registered manager, behavioural specialist, registered nurse and team leaders. One staff member told us, "The team atmosphere is better now; we have got clear direction." Another told us, "We look at what needs to be done and things are delegated so things don't get missed."

The community learning disability team (CLDT) told us, "There is a new management structure at Cheshire House which has improved the consistency of the staff approach to supporting people. We don't need to be involved as much as we used to be."

We asked the registered manager what they felt the greatest achievement was for the service. They told us it was successfully supporting one person so they did not need to be re-admitted to hospital. The CLDT also commented how the service had provided a high level of consistent support for this person which had prevented a re-admission to hospital.

We were aware of an incident at the home that had involved the local police. Following the incident meetings had been held with the local police to inform them about the home, people's needs and how the staff supported them. The local community beat police officer now popped into the home on a regular basis. This meant they knew the home, the people living there and the potential challenging behaviour people may have. This meant the service had worked collaboratively with the police to improve the response to any future incidents at the service.

We saw there was a quality monitoring system in place to audit various aspects of the service. This included weekly and monthly medicines audits, monthly audits for infection control, people's care files, finances and health and safety. Monitoring sheets were used to track staff training and supervisions were being completed. All incidents were analysed to identify triggers and review how people had been supported during the incident. Changes to behaviour support plans were made where needed.

The providers Operations Manager visited the service on a regular basis and completed a monthly audit. An action plan was written to address any issues identified. We saw the actions were checked at the next monthly audit and had been signed off by the registered manager. We were told the nurse and team leaders also received a copy of the Operations Manager's audit so they knew what had been found and what actions were required to be completed.

Directors of the provider also visited the service. During our inspection we observed people and staff were able to talk freely with them. The registered manager told us they felt well supported by the provider.

An internal expert by experience visit had been completed in March 2017. This was undertaken by a person who was supported by Consensus and visited other services to talk with the people living there. The report stated that people were happy with the staff and how staff communicated with them.

This meant the service had a system of audits to monitor and improve the service.

The registered manager told us the provider was implementing a development programme for staff. This was aimed at developing staff skills so they could progress to team leaders or deputy managers and increasing staff retention across the organisation.

We saw, confirmed by staff, that regular team meetings were held. Separate meetings were also held for team leaders. Staff said they were encouraged to raise ideas and concerns at the meetings. The behavioural specialist also attended these meetings so open discussions could take place with regard to how individual people were supported to reduce their anxieties and manage any incidents. This meant staff were involved in developing the plans for supporting people. All staff said they now felt more engaged in agreeing and developing the care and support plans in place at the service.

We were shown two different staff surveys that the provider conducted. One was a survey of all staff working at Consensus services in the north of England. This was completed by an external organisation and the results collated to identify what staff thought the company did well and where the staff thought improvements were required. A separate survey was carried out by the Consensus central Human Resources team for individual services. The results were collated and sent to the registered manager. The registered manager said they would produce an action plan based on the results of the survey. We did not see an action plan for the 2016 staff survey, conducted prior to the appointment of the current registered manager. However we noted the staff had commented that they had not received regular supervisions or team meetings. As noted in this report supervisions and team meetings were now taking place.

An annual survey was sent to each person who used the service. This was due to be repeated at the time of our inspection. Surveys were also sent to other professionals involved in the service to gain their feedback. Families received an annual survey. We saw the registered manager had also introduced regular meetings with families where appropriate. This meant the service sought the views of a range of people and professionals and sought to improve the service from the responses received.

The registered manager attended meetings with other registered managers from the Consensus group. The

also went to 'well led' seminars aimed at sharing good practice between the different Consensus services.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). At the last inspection we found not all incidents had been reported to the CQC as required. At this inspection we checked the records at the service and found that all incidents had been recorded, investigated and reported correctly.