A C L Care Homes Limited

Arthur Court

Inspection report

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Ratings

Overall rating for this service	Outstanding

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 6 & 7 July 2016. The service provides a residential service with an emphasis on rehabilitation for up to 19 people with a variety of mental health problems and the service was full at the time of inspection. People have their own bedrooms many of which are ensuite, there is a shaft lift and a variety of aids and adaptions are in place to aid people with minimal mobility difficulties. This service was last inspected on 8 January 2014 when we found the provider was meeting all the regulations inspected at that time.

There was a registered manager in post who was available in the service Monday to Friday and included in a telephone on call rota at weekends to advise staff if needed. A registered manager is a person who is 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 were provided with a safe, clean environment that was maintained to a high standard, with all safety checks and tests routinely completed. There were enough skilled staff to support people and provide continuity, and the provider implemented recruitment procedures quickly when staff left, with an emphasis on recruiting skilled qualified staff. New staff were inducted appropriately into their role and given opportunities to meet regularly with members of the management team individually and in staff meetings, they said that they felt well supported and listened to.

Staff understood how to keep people safe and protect them from harm, they understood how to respond to emergencies that required them to evacuate the building quickly and safely. It was recognised that some restrictive practices were necessary although there was a clear culture of least restrictive practice and positive risk taking embedded across the service. Risks were appropriately assessed to ensure measures implemented kept people safe.

People were encouraged by staff to make everyday decisions for themselves, but staff understood and were working to the principles of the Mental Capacity Act 2005 (MCA) where people could not do so. The MCA provides a framework for acting and making decisions on behalf of people who lack mental capacity to make particular decisions for themselves.

There was a strong rehabilitation focus helping people to regain a meaningful life. Staff worked in partnership with people to promote and encourage their rehabilitation and skills development and included them in every aspect of their support. People were placed at the centre of the service and their involvement and empowerment was clearly embedded. They were able to contribute to their own care records through regular meetings with their key workers (in this service the keyworker was involved in planning with the person how their care needs were met, and agreeing with them the amount of assistance they required) this may also involve participating in discussions about the persons support with professionals and attendance for example at reviews. They were treated with dignity, respect and kindness and their relationships with

staff were positive. People understood how to complain and felt confident of approaching staff with any concerns.

Medicines were well managed. People were encouraged to eat healthily and chose from a selection of food provided for them, they had opportunities to self-cater. Their health and wellbeing was monitored closely and specific staff had the responsibility for doing this each month as a preventative measure; any issues arising from these checks were quickly alerted to health professionals.

People were supported to develop relationships and maintain those that were important to them, there was excellent support for them to use new technology to do so and free access to telephone and internet was available to them, many were supported to purchase tablets and smart phones and given support in how to use them. Video link facilities were available so that people could more easily maintain their relationships with the people close to them, staff also used video link with external care co-ordinators who might otherwise be unable to attend care programme meetings locally due to distances so that everyone could contribute to care decisions.

Staff worked closely with their mental health team partners in the local teams and allocated care co-ordinators to ensure that peoples changing needs were identified and solutions found and also to celebrate achievements.

People told us they were happy, they enjoyed the freedoms the service provided and the variety of activities offered in house and in the community, they were supported to access educational and voluntary work opportunities. Professionals held the service in high regard and thought the service was effective in working with people with complex mental health needs and supporting, motivating and preparing them for life in the community.

People were routinely asked to comment about the service and their views were analysed and action taken where improvements could be made. People could join in at the end of management meetings which were open to all. The providers took an active interest in the service and were present several times each week, speaking with staff and the people supported, they attended weekly management meetings and ensured identified shortfalls were addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe

There were enough staff available to support people and recruitment procedures checked the suitability of staff to undertake their role.

Medicines were well managed. Staff understood how to identify and respond to abuse. The premises were well maintained and routine checks and tests of fire detection equipment and gas and electrical installations were undertaken. Staff understood the action to take in emergencies to protect people from harm and evacuate them safely.

People were supported to take risks and comprehensive assessments ensured this was undertaken safely to reduce the risk of harm. Accidents and incidents were monitored and actions taken to minimise the risk of recurrence.

Is the service effective?

The service was effective

Staff received a comprehensive induction to their role; they received essential and specialist training to give them the right skills. There were regular opportunities for staff to meet with a member of the management team regularly.

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The registered manager ensured that people were supported in line with the principles of the Mental Capacity Act 2005; people's consent was sought by staff in respect of their care and treatment.

People made choices about what they ate and health eating was promoted, their health and wellbeing was monitored and they were supported with health appointments when needed.

Is the service caring?

The service was caring

There was a strong, visible person-centred culture, and the

promotion of independence and preparation for a return to a life in the community. Feedback from people was positive and relationships between people and staff were strong, caring and supportive.

People's privacy and dignity was respected, staff were responsive, caring and enthusiastic about peoples care and their progress. Staff respected and valued people; they were attentive but discreet, and supported people to make decisions about their care.

Staff supported people to maintain links with their families and friends. They supported and advocated for people in dealing with other agencies. People's input was valued and there were a number of initiatives to listen to their views or involve them in improving their experience in the service.

Is the service responsive?

Good

The service was responsive

People were comprehensively assessed prior to coming to live in the service through a process of transition to ensure their needs could be met. People were routinely consulted about their care and treatment which was kept under review on a weekly basis.

People were provided with activity schedules that took account of their need to develop independent living skills and support their individual interests and preferences.

There was a complaints procedure and people felt comfortable with staff and able to raise concerns if they had them.

Is the service well-led?

Outstanding

The service was well led.

The service used inclusive ways to enable people and staff be empowered and voice their opinions in all aspects of the service. Staff were motivated and spoke enthusiastically about working at the service.

There was a strong emphasis on continually striving to improve which was driven by the providers and registered manager. Staff practice was informed by policies and procedures that were kept updated.

Close monitoring by the providers and management team

ensured that quality and safety issues were addressed quickly. People were asked to give their views and were welcome in management meetings, they were listened to and their responses were analysed and informed service development.

Care Quality Commission

Arthur Court

Detailed findings

Background to this inspection

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

This inspection took place on the 6 & 7 July 2016. People sometimes found the visits of professionals intrusive so the inspection team consisted of 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 also looked at all the other information we held about the service, including previous reports, complaints and notifications. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

People chose whether they wanted to participate in the inspection or not, we met eleven of them during the inspection seven of who provided more in depth insight into living in the service.

We spoke with one of the providers, the registered manager, deputy manager and three support staff. We have contacted five social and health care professionals who know the service well.

We looked at three peoples support plans, health records, individual risk assessments and evidence of activities. We also looked at medicine records, operational records for the service including: staff recruitment, training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records, general risk assessments and quality assurance surveys and audits.

Good

Is the service safe?

Our findings

People told us they thought there were enough staff with the right attitudes to support them. One person commenting about the accommodation told us that they had everything they needed in their room but particularly loved the new bathroom and the underfloor heating.

A professional commented that in regard to risk management the service was proactive in identifying relapse in people and worked in partnership with the local mental health team to find the least restrictive options –"In my opinion Arthur Court does provide a safe and supportive, client centred environment". Another said "The home provides a safe and caring environment with an emphasis on rehabilitation. The management and staff are very effective in spotting potential safeguarding issues and dealing with them with support from the local team and we have had many examples of this."

Only trained staff were able to administer medicines but a few staff were trained in all aspects to ensure they knew the procedures for ordering, receiving, booking in medicines and their disposal. The competency of staff was assessed annually; they received medicine training updates at regular intervals to keep updated with any changes in practice. Medicines were securely stored with daily recording of storage temperatures recorded. Staff ensured appropriate stock rotation and boxed, bottled medicines and creams were dated upon opening.

Medicine administration record (MAR) charts were completed properly with the appropriate use of codes when medicines were not administered. A protocol was in place for those medicines that were not for everyday use to make clear in what circumstances these could be used for particular people, we have recommended this information for each person is copied across to the medicine records so this is more easily accessible to staff and this is an area for improvement.

The staff were knowledgeable about the safeguarding reporting process and raised alerts on behalf of people when they identified potential abuse. Staff demonstrated a good awareness and understanding of the different types of abuse people could experience and from whom; they understood the process of reporting either through safeguarding adults or their internal whistleblowing procedures directly to through their line management or to external agencies if necessary. Staff received initial and refresher training in protecting people from abuse so their knowledge of how to keep people safe was kept up to date.

Each person had an identified set of risks specific to their own needs, these were individualised and informed staff of the risk and the measures in place to minimise risk of harm occurring, they took account of each person's personal awareness and understanding of danger and risk. Measures were implemented to reduce the level of risk so people were protected from harm when undertaking activities outside or from risks within the environment. For example some people were being provided with tea making facilities in their bedrooms, dependent on the assessed risk to themselves or others.

Staff said that informal risk assessments were also conducted every time someone was due to go out or participate in an activity; at that time staff assessed their mood and ability to undertake the task in the right

frame of mind. Where there was a question over a specific person staff took steps to delay any proposed outing for a short while until the person's mood improved and they were less likely to pose a risk to themselves or others. Risk assessments were kept updated and peoples progress was discussed weekly when levels of risk would also be reconsidered. Risks people may be subject to within the environment were also assessed. We did note that the risk assessment for the garden that included the pond was insufficiently detailed to show the other measures also in place that keep people safe when in the garden area for example CCTV monitoring, this was discussed with the provider at inspection as a minor improvement.

There were a low level of accidents and incidents; many were linked to slips, trips and falls or incidents of behaviour that were challenging to others. These were recorded clearly. All accidents and incidents were monitored closely by the providers and registered manager and discussed within the staff team as to whether any changes were needed to the support people received and the assessment of risks to prevent similar events in future.

The premises were kept clean and tidy and décor and furnishings were provided to a high standard. A maintenance team were employed to ensure repairs and building works were undertaken safely and in a timely manner. A development plan was in place and works were prioritised to coincide with the seasons and also with when rooms became vacant. The planned development included, works to the roof, an upgrade of bedrooms to provide everyone with half or full ensuite facilities, soundproofing of ceilings in communal areas to reduce noise for people in bedrooms above these areas. Communal bathrooms had also been upgraded and some hallway areas updated.

To ensure systems to keep people safe were in good working order, internal checks and tests of fire safety systems and equipment were made regularly and recorded. Fire alarm systems were regularly maintained. Staff knew how to protect people in the event of fire as they had undertaken fire training and took part in practice fire drills. Personal evacuation plans were in place for each person to ensure their needs had been assessed should they need to be evacuated. An emergency contingency plan had been developed to inform staff of what actions they needed to take in respect of any event that may impact on the operation of the service. An out of hours on call arrangement was also in place so that senior management staff and/or the providers could be alerted to issues arising and provide support and guidance to staff.

A safe system of recruitment was in place that ensured the provider took appropriate steps to make necessary checks on prospective staff. We checked files for three newer care staff; these were well organised with an index and information was easy to find. People in the service were given the opportunity to interact with applicants and to provide feedback on whether they had the right attitudes and attributes to support them, their feedback was integral to that of other staff and given due weight in considering new staff for posts. Files viewed contained all the legally required documentation that showed the provider had undertaken a thorough check of applicants and these processes helped the provider make safe recruitment decisions and help prevent unsuitable people from working with people who use care and support services.

There were enough staff to ensure people's needs were met. People were self-caring but needed the encouragement and prompting of staff to motivate them and enable them to engage in the day to day routines of the service and also to develop and follow their own routines without spending too much time in their bedrooms or isolating themselves from others. Staff were rostered across all three services in the group, and could be used flexibly if issues requiring more staffing emerged. Agency staff were never used; this provided continuity for people who received support from familiar staff who understood their needs well. Staff worked long days with time off in between, additional staff support was provided between 10:00-7:00 pm each day when people were most active. These extra staff hours provided flexibility to enable people to be supported into the community with one to one activities without the need to worry that they

needed to return for an early shift change.

Good

Is the service effective?

Our findings

One person told us "The staff are very good here, X in particular knows me inside out, I get angry sometimes but they know that I don't mean it, they talk to me about it."
Health and social care professionals told us: "This is a good service"; "They meet the needs of some very challenging people and have a good staff team".

"I have always found the staff at Arthur court to be particularly client centred and proactive to engage with care coordinators to discuss changes in presentation and risk profile".

Staff commencing work at the service were required to participate in a supernumerary capacity a range of different shifts prior to their inclusion on the rota as a full team member. New staff were expected to complete a period of induction that included the completion of the care certificate (The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life).
New staff were on probation for six months and received support through probationary meetings for the first three months these meetings assessed their competency and progress based on feedback received from other staff and people in the service, these happened on a two weekly, monthly and quarterly basis, after which time they received supervision to the same frequencies as other staff.

Staff were supported to deliver effective care by means of supervision and appraisal of their work performance, to identify additional training requirements and manage performance. Staff and managers discussed performance in one-to-one supervision sessions. We saw evidence of this in the records we looked at. Staff said they felt well supported by the supervision process; they received an annual appraisal of their work performance and discussion of further development and training needs. All staff who qualified had been provided with an appraisal in the last 12 months.

Supervision session frequencies had been reviewed recently and these had now moved onto a monthly basis and at each session staff covered a theme for the month and their responsibilities within this, for example, physical health and wellbeing of people in the service. Staff were routinely thanked for their support and work in the service by for example team meals, or an additional leave day.

There was a strong focus on opportunities for learning and sharing across the service. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care and the development of specialist expertise within the staff team. The provider was proud of the service staff ability to react appropriately to and manage situations in partnership with the local mental health team. In addition to the mandatory range of training staff were provided with additional training relevant to the specific needs of people in the service was provided. For example, staff attended Autism awareness training to enable them to understand and support appropriately one person with those needs. Staff were proactively supported to acquire new skills and share best practice. The training records we saw showed that staff had accessed a range of training so they were able to meet people's needs.

Staff understood and were compliant with the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff had a good awareness and understanding of mental capacity and consent issues. Some people were subject to social supervision under Part 111 of the Mental Health Act (MHA) this meant there were certain restrictions placed on their discharge from hospital which if breached only once, precipitated an immediate recall back to hospital, people were aware of these conditions. Staff supported people to ensure they kept to the conditions and were proactive in challenging conditions that made it difficult for the person to participate fully in their rehabilitation programme without breaching conditions. Mental capacity assessments were only carried out when there were doubts about a person's capacity. This meant that people received appropriate support to help them make specific decisions for themselves. At the time of inspection no one was subject to a deprivation of liberty safeguards (DoLS) authorisation.

There were two kitchens; the main kitchen was awarded a five star rating at the last environmental health kitchen inspection. The service employed a cook six days per week for the main kitchen who was aware of and ensured that people's special dietary requirements were catered for. Menus reflected people's food preferences, and healthy options were provided and people were encouraged to eat healthily.

Breakfast was provided as a self-serve arrangement of different cereals and toast, a heated trolley was used for the lunch meal offering alternatives that people could choose from eating as much as they wanted and in the combinations they wanted to eat it.

There was also a 'residents kitchen' which was used daily by people who planned, shopped and cooked their own meals with staff support, they also made snacks for themselves at other times and had access to a small store of stock food items, they were provided with a small budget to enable them to purchase food to cook. Everyone had their own food cupboard and fridge, and the message of healthy eating was promoted by staff when supporting people to shop and cook for themselves.

Some people were supported to access weight loss classes if they chose. A community nurse visited every four weeks to talk with people about diet, weight and related problems. If there was any concern about a person's nutritional intake this was monitored and advice from external health professionals would be sought. A few staff were identified with the specific responsibility of monitoring people's health, each month they undertook a series of health checks including blood pressure, temperature and weight monitoring. These staff had also been provided with advanced diabetes training to help them understand the condition and everyday impacts on people. Records of people with diabetes made clear the actions needed to support people, these would benefit from all the information held in regard to the impacts of high and low glucose levels being pulled together in one area of the support plan for ease of reference for staff and this is an area for improvement. Blood glucose monitoring was closely monitored and readings mapped on a graph to indicate emerging patterns which staff used to alert medical professionals if needed.

The importance of regular screening was explained to people, who were required to sign a refusal for treatment form if they chose not to undergo any health check they were invited to attend. Health check findings including blood glucose levels were recorded and any changes from the 'norm' were discussed and referred to health professionals if necessary. Everyone was registered with a GP practice of their choice, other health needs in respect of dentist, optician, chiropodist and hospital appointments were made as and when required and with the permission of the person. Specialist support could be accessed quickly from psychiatric teams, and additional support such as occupational or physiotherapy can be arranged

separately if needed.

Outstanding ☆

Is the service caring?

Our findings

Health and social care professionals commented, "The staff are willing to encourage service users to develop independent living skills", "The clients I engage with who are supported at Arthur Court always appear to be satisfied with the level of support they receive". Another said "They build their services around the service user". A third said "They have successfully moved service users on to live in a more independent setting; where this has not been possible they are able to maximise their skills and abilities to make them more independent with in the home environment".

People were universally complimentary about the care they received, from kind, friendly and approachable staff. People said staff were always available for them to speak with at a pace that suited them. We observed staff were easy going in their manner with people, there was no sense of rush and interactions were respectful and professional. One person said "I feel very chilled here, they help me with hoovering they look after me and X but I can also do things that I want to do for myself".

People we spoke with felt they had found their place within the service and that staff cared about the support they gave. They were relaxed and comfortable in each other's company or just sitting in the environment where other people were. Some people felt comfortable and wanted to share information about themselves or to show us things that were important to them, but staff were mindful when people were speaking if their responses bordered on more private and confidential information they encouraged them to continue those conversations in a more private setting.

People were respected and valued as individuals; they were empowered and meaningfully involved in making changes in the service and decisions about their care. For example people had regular meetings with their key worker to discuss their care and support needs and ensure these were in accordance with their preferences where this was not restricted through legislation. People were also actively encouraged to attend management meetings at the 'any other business' stage where they could raise issues that mattered to them. The provider told us that when the garden was redesigned a smoking shelter was added as this was an important way in which people could relax and de-stress, however at times when people were stressed dynamics within the service can suffer and people need to be able to be away from others when smoking. The provider understood the necessity of this and a second shelter was provided quickly and people really appreciated this option. When recent upgrading of the communal rooms was undertaken people were consulted about what colours they would like used in the communal areas; a survey specifically around this was also conducted and people were informed of the outcome.

Several people were unable to read and the provider had introduced multiple choice questionnaires that used voice recognition software to ask the questions and a staff member helped the person select the answer they wanted to choose. People were encouraged to develop their IT skills and were provided with training for this. Sixty-five percent of people were using new technology such as smart phones and tablets; these had helpful applications for example a medicines application which enabled the person to look up their prescribed medicines and alert them to the side effects they may experience. This enabled people to be more aware of the medicines they took. Another application used was for people who were diabetic this

helped them with managing their diet and eating healthily. This empowered them to understand their condition better and how they could influence the way it was managed.

Staff were mindful to protect the confidentiality of the people they worked with and records were held securely. Staff spoke to people in a dignified way and observed people discreetly intervening if they thought people wanted help or support without drawing undue attention to them, this approach ensured the person's dignity was maintained.

People had their own space and could be private and spend time alone in their rooms away from others when they wished; they all respected each other's privacy, people had keys to their room and some had thumbprint locks to lock their rooms when they were out. People had personalised their bedrooms to reflect their individual tastes and preferences and these were full of possessions mostly gathered since coming to live in the service such as books, dvds, musical instruments; two people had pets that they cared for and which provided them with comfort and one person told us they found the care of their pet an outlet for when they were feeling stressed.

The ongoing development and upgrade of the environment and the empowerment and enabling support of staff promoted the comfort and dignity of people living there and encouraged a culture of rehabilitation. Relapses happened but were infrequent and for the majority of people in the service their time at Arthur court was the longest they had ever spent out of hospital.

The provider and staff demonstrated that they are strong advocates for anyone they were supporting even where this meant organising evening meetings to meet with representatives for the person, or advocating and upholding a person's rights of access to their children and liaison with courts and Children and Families services to ensure this happens, travelling long distances at their own expense where necessary and sometimes at short notice to uphold people's rights.

For people who were subject to restrictions under Part 111 of the Mental Health Act, the provider had ensured they were not excluded from opportunities to travel abroad and had taken the time and effort to advocate on their behalf and take the necessary steps, assessments and precautions to satisfy the requirements of their discharge arrangements and the Home Office.

One person was on preserved rights and so their funding was well below that of other people and they were left with very little personal monies, this created an imbalance with other people and so in order that they did not miss out on trips abroad or on new clothes the provider had taken on the responsibility of financing these things for them. In order to balance out the fact that people in the service had a wide range of disposable income with some with less money than others the provider had made all telephone calls and internet use free to all the people in the service.

We observed staff took time to listen and interact with people so that they received the support they needed. We saw many positive interactions between people and staff. People told us about their enjoyment of the farm project they attended. Others said about special events they were supported to attend by staff, holidays abroad they had participated in, and concerts they went to, specific museums they wanted to go to or bookshops they were interested in.

People were supported to maintain contacts with their friends and relatives and also to develop personal relationships; staff recognised they sometimes had to overcome initial difficulties to ensure people received the right support from families and friends when away from the service. Staff acknowledged that working with friends and relatives of people in the service required sensitive handling to help families to understand

how they could best help their relative in their rehabilitation back into the community.

People received ongoing support and encouragement to help them reach their rehabilitation potential, for example to budget for plan and cook meals independently. Their potential for independence was developed at a pace to suit them. As a rehabilitation service this was not a home for life but there was not a set timescale within which people were expected to move on, although some professionals indicated they would like to see more focus on this. The provider was able to give many examples of people who had moved on to independent living, marriage and living a full life in the community.

Staff were mindful that there were people in the service whose needs were moving more towards full time residential care due to age and physical health deterioration and may not be able to continue to have their changing needs met safely within Arthur court. The provider and staff ensured they kept care co-ordinators informed of people's changing needs so that early intervention could be made with adequate time given to ensure their needs were reassessed and they were prepared for the need to move on, when the right type of service was identified for them people were able to go and visit prospective services and discuss options with their care co-ordinator. When people moved on they were always made welcome at Arthur court when they chose to visit or came for occasional meals or events.

Good

Is the service responsive?

Our findings

A health professional told us: "When I visit the home I will invariably receive positive feedback from the service users I see about the home" and "Their record keeping is of a very high standard and they will remind the local teams of any outstanding Care Programme Approach (CPA) reviews and will often request medication reviews if they feel it necessary." One person told us that they had requested a reduction in their medication; this request was to be discussed with them within their CPA meeting which they were happy with.

Admission to the service was via hospital usually for people with a long history of frequent hospital admissions. Recently the service had begun to accept more people from secure settings many of whom have spent years in institutional environments and needed support to cope with the lessening of restrictions in their day to day lives. The change in the nature of referrals has promoted the development of specialism and expertise within the staff team to work effectively with people with these needs in response to decreasing access to resources within the mental health sector.

Each person admitted had undergone a long period of assessment and transition which can take up to a year to complete; assessments were supported by requests for additional multi-disciplinary reports to inform the decision. Transitions were undertaken at a pace to suit the person being assessed and their engagement with staff and other people would be a key consideration in whether they were accepted or not. In the first month following admission people newly admitted were given key work support from the registered manager, a care programme approach (CPA) review would happen upon a trial period being completed. Staff said that they would be made aware of any prospective admissions through daily handovers and their feedback would be sought during the transition process to determine if the placement was going to be offered or not. The majority of people supported and considered for placement would have a link to the area the service was in but some people came from other parts of the country due to placements that would meet their needs not being available in their home area.

People had capacity and could do most things for themselves; the focus on their support was on helping each person to take greater control of their life, develop skills for living, and to support their rehabilitation back into mainstream life for some with ongoing supervision. Staff respected and valued people as individuals and empowered them to make choices and decisions about their care. Their individual preferences and needs were always reflected in how care was delivered.

People we spoke with commented positively about living in the service and how the quality of their lives had improved, they said that staff were always willing to sit and listen, they met with their key worker often to discuss their care and support needs and felt involved in discussions about their support. For those who were subject to Part 111 of the MHA they were aware that if they breached their conditions they would be recalled to hospital.

People's care was recorded on a computerised client management system and identified the areas that people needed support with and how this was provided, a hard copy with a profile of each person was also

available and used by new staff to familiarise themselves with each person's support needs. Monthly reports and weekly management discussions of each person's progress were used to update care plans on a monthly basis. Daily reports of each person's mood, activity and general wellbeing were recorded by staff on every shift.

The team were knowledgeable about people's individual 'tells' and triggers that signified some change in their moods or mental health and sought to provide distractions and interventions to de-escalate situations from arising. People's individual care and support was coordinated with other professionals and staff worked closely with Care Programme Approach (CPA) co-ordinators to ensure everyone was kept informed about objectives, goals, and achievements and what worked well and what worked less well. They were kept informed of changes and where necessary meetings were called early or staff in the service reminded CPA co-ordinators of when these needed to take place to ensure these reviewed people's progress on a regular basis.

The provider informed us that it had been difficult on occasion to get professionals together for CPA meetings especially where some co-ordinators may be located on other parts of the country. The service had taken the initiative to ensure that people had their CPA meetings on time and had facilitated meetings for some people through a video link which the person had full participation.

The service had an activities co-coordinator who spent time when people were first admitted to understand what things they liked to do or were interested in. People were used to structure so it was important that their week had some structure to it but was filled with things they chose to do, and activities that helped them towards rehabilitation such as activities in the community or support to develop daily living skills such as cooking, laundry, shopping, and budgeting, there were some social in house activities that included some external entertainers who visited and also board games and quizzes, puzzles that people enjoyed doing on their own or with other people.

In house activities increased in the winter months but in summer people were more likely to want to spend time out of the service during the week and made more use of the garden. People were given opportunities to develop their I T skills and more than 60% of people in the service now had use of a tablet or smart phone.

If people requested it they were provided with access to voluntary work opportunities in the community, this participation in the community helped people develop their role and responsibilities as a citizen with many of the freedoms and choices that brings and which were previously restricted. People were encouraged to develop their daily living, social and creative skills, for example one person in the service had a book published since coming to live there. People had taken an active role in suggesting ideas for the upgrade of the garden on a Chinese theme and this provided a quiet relaxing area where they could sit. Some people enjoyed helping with the garden. The suggestion of two smoking areas instead of one to give people choice and remove the possibility of flashpoints had also come from people in the service and had been implemented.

A complaints procedure was clear and displayed for people and visitors to see. People said they found all staff approachable and would feel comfortable about raising any concerns they might have to them. People had opportunities through a range of forums in which they could raise any concerns they might have including one to one monthly meetings with their key worker, resident meetings and survey questionnaires, they could also sit in on the 'any other business' section of the weekly management meeting if there were issues they wanted to raise. The complaints log recorded that no complaints had been received in the last 12 months.

Outstanding ☆

Is the service well-led?

Our findings

Health and social care professionals spoke positively about the service commenting: "The owners are very involved in the service too which helps." Another said "I have no hesitation in stating that, in my opinion, they provide a high standard of care. A third told us "The management team have endeavoured to foster good working relationships with the community mental health team; It is well managed".

One person commented "It's perfect the way it is run", other people told us they found the provider and registered manager were always available and always approachable and they felt comfortable talking with them. Feedback from people was positive about the way staff treated them and discussions with them showed that they felt that staff went out of their way to provide high quality care.

At the beginning of the inspection, the provider registered manager and the deputy provided an overview of the service and their achievements to date since completing the Provider Information Return (PIR) more than six months previously. This showed that there was a strong commitment to quality improvement and innovation with plans for service improvements, for example the development of video link conference facilities to enable multi-disciplinary communication, installation of sound proofing for the benefit of people whose rooms were located over communal areas to protect them from excessive noise, the introduction of ensuite facilities for everyone to give people additional privacy, the development of a culture that encourages the involvement of people in the operation of the service including staff recruitment, management meetings, policy development and taking on roles and responsibilities within the service by choice for example gardening, help organising events and day trips. The provider was keen to build on the expertise that has built up within the team to develop the service into a centre for excellence providing a holistic specialist support approach for people with mental health needs.

There was a good system of governance with handover meetings at every shift change. Staff said there was a clear management structure and lines of accountability, they felt empowered in working with people because they knew there was always someone available they could ask advice or seek support from if they needed it. Communication between staff was good and an email system was used that ensured all staff received information about important changes at the same time; they also received comprehensive handovers between shifts.

The providers were accessible and visible through visits to the service each week they had constant oversight of the service and what was happening through their attendance at weekly management team meetings where they discussed peoples progress and operational matters but in the 'any other business' section of the meeting, people, staff and external professionals were welcome to sit in to discuss issues or to listen if they wanted to. There were some standalone audits conducted by staff and completion of necessary safely and cleaning checks each week in addition to audits of medicines and health and safety. Feedback from weekly meetings and some audits on identified shortfalls was incorporated into a service development plan with timescales for completion of outstanding issues.

There was a clear commitment to the involvement of people in the development of the service, the culture

of empowering them through resident meetings, sitting in on management meetings, participation in recruitment of staff, and routinely seeking their views was embedded into the day to day practice of staff in the service. The management team prioritised safe, high quality care and promoted equality and diversity. Every effort was made to motivate people and staff to succeed.

The provider's philosophy that "the general rights of each client are a prime consideration at all times" establishes the principle of placing people at the centre of the delivery of good quality care and this was embedded into staff practice. We observed staff displaying these values during our inspection, particularly in their commitment to the people they supported and the maximising of their potential for experiencing new things and for greater independence.

People worked together with staff to plan care. We saw staff spending time talking with people, and people told us that they understood their care support and conditions of placement in the service and felt involved in influencing what and how it was delivered. For example the key worker meetings people had each month contributed to their own care records updates. There was good engagement between people and staff. The atmosphere within the service on the day of our inspection was open and inclusive. Staff were seen to work in accordance to people's routines and support needs. Staff told us that they felt supported and listened to, they felt communication was good and they were kept well informed of important changes to operational policy or the support of individuals. Occasional formal staff meetings were also held several times each year staff felt this was adequate because of the involvement and close monitoring of the provider and the email system that ensured all staff were equally informed.

The providers were members of KICA (Kent Integrated Care Alliance) and a member of Social Care Commitment. A director of the organisation sat on the Kent County Council (KCC) Executive Safeguarding Board, the KCC Learning & Development Board, and the south Kent Clinical Commissioning Group (CCG) Executive Board and also a Kent based Care Association Board as well as the KCC Quality & Care Committee. They felt membership of these bodies gave them insight into plans for future mental health provision both nationally and at local level and this informed and developed and direction of their services. They felt networking with people deciding policy enabled them to have influence in some areas. Early education about proposed changes helped them to change the way the service worked with people allowing time for the impact of proposed changes to be lessened and people's expectations managed for example when grant funding for people moving into their own flats to furnish the flat changed to a loans system that people needed to repay; this caused great anxieties but prior knowledge of the change enabled service staff to work with people and manage their anxieties around this change.

To keep updated with important information and changes to legislating and guidance the providers subscribed to sites such as: Social Care Commitment, Skills network, CQC, Immigration News, Skills for Care, Public Sector Executive, National Health Executive to receive regular newsletters and up to date information.

The providers model of care and experience prompted enquiries for advice and guidance from other providers, their knowledge and experience in regard to mental health care had been influential in the provision of a mental health course at the local college and they had imitated the development of a farm project a number of years ago to provide a voluntary work opportunity for those people interested in working with animals, this had subsequently grown to provide a resource to a wide range of people in the community. The service provider and staff worked in partnership with the local mental health teams to ensure people's rights were upheld and they were empowered to make decisions for themselves.

Information about individual people was clear, person specific and readily available to staff, people were

made aware that they could access their records if they chose with the support of a key worker. The language used within records reflected a positive and professional attitude towards the people supported.

Staff had access to policies and procedures which were kept updated by the provider to ensure changes to legislation and good practice guidance were incorporated and staff were made aware of policy updates and reminded to read them. This helped them to ensure they were working to the requirements of the Health and Social Care Act 2008 and the fundamental standards. Policies and procedures were reviewed regularly by the management team to ensure any changes in practice, or guidance is taken account of, staff were made aware of policy updates and reminded to read them.

People and other stakeholders were asked to give their views about different aspects of the service several times each year, this information was analysed and any shortfalls highlighted addressed, an analysis of the findings and actions taken as a result were displayed for people to see and comment on.