Dove Care Limited

Lifestyles

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 22 June 2016 and was unannounced. We previously visited the service in April 2014 when we found that the registered provider met the regulations we assessed.

The home is registered to provide accommodation and care for up to 19 people with mental health needs and / or a learning disability. On the day of the inspection there were 15 people living at the home. Two people share a flat within the premises and other people are provided with a single bedroom. The home is situated in the city of York, in North Yorkshire close to transport routes and local amenities. There are various communal areas where people can spend the day and a small garden. The first and second floors of the home are accessed by stairs so people who live at the home have to be active enough to manage the stairs.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at Lifestyles.

People told us that they felt safe living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Any identified risks had been considered and risk assessments recorded how to manage these risks to promote people's safety and well-being. Accidents and incidents had been recorded and appropriate action taken to address any risks, although more analysis of accidents and incidents would help to identify any trends that were emerging.

Staff told us that they were well supported by the registered manager, and felt that they were valued. They confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. This included training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Discussion with the registered manager and staff showed that the principles of this legislation was understood.

We checked medication systems and saw that medicines were recorded and administered safely. We had

some concerns about the recording of controlled drugs (CDs) and these have since been rectified. Staff who had responsibility for the administration of medication had received appropriate training.

People who lived at the home, visitors and social care professionals told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, visitors and staff.

People told us that they were very happy with the food provided and people's nutritional needs had been assessed. We observed that people's individual food and drink requirements were met. People were able to use the kitchen to prepare meals if they wished to do so, within a risk management framework.

No complaints had been made to the home during the previous twelve months but people were aware of how to make a complaint and told us there was always a member of staff for them to speak to if they had any concerns. There were systems in place to seek feedback from people who lived at the home, care professionals and staff.

Staff, people who lived at the home, visitors and social care professionals told us that the home was well managed. Quality audits undertaken by the registered provider and registered manager were designed to identify any areas of improvement to staff practice that would promote people's safety and well-being. Staff told us that, on occasions, feedback received at the home was used as a learning opportunity and to make improvements to the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse (including potential incidents) to the relevant people.

The premises had not been maintained in a safe condition but this was promptly rectified.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and people told us they liked the meals at the home. We saw that different meals were prepared to meet people's individual nutritional needs.

People had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by

staff, and people were encouraged to be as independent as possible, with support from staff.

People who lived at the home respected each others privacy, dignity and lifestyle choices. They told us that their privacy and dignity was also respected by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests, their preferences and the people who were important to them.

People were encouraged to take part in meaningful activities and occupation, and to keep in touch with family and friends.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. People who lived at the home were also invited to comment on the care and support they received.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed. The registered manager ensured that staff kept up to date with good practice guidance.

There were sufficient opportunities for staff and care professionals to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

Lifestyles

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22 June 2016 and was unannounced. The inspection team consisted of two adult social care (ASC) inspectors.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We received the PIR within the required timescale.

On the day of the inspection we spoke with four people who lived at the home, a visitor, two members of staff and the registered manager. Following the day of the inspection we spoke with three social care professionals.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment records for one member of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Lifestyles. One person told us, "Yes, it's safe here. I get on well with folk here – they are all friendly lads" and "I definitely feel safe here." A visitor to the home told us, "[Person who lives at the home] lives an independent life but with safeguards around them." Social care professionals told us, "[Name] definitely feels safe now and is very happy there."

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. Staff were able to describe different types of abuse and the action they would take if they became aware of an incident of abuse or a potential incident. Staff told us that they would report any concerns to the registered manager and that they were confident they would be listened to and that appropriate action would be taken. Staff said that they used de-escalation techniques to manage any behaviours that might be challenging, and that they never used physical restraint.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments in respect of hygiene, food consumption, money management, medication and cooking. We saw that risk assessments had been reviewed to ensure they remained relevant and up to date. Risk management plans had been developed by NHS practitioners for areas such as the risk of self harm or exploitation and these were included in people's care plans. One person had a risk management plan in place in respect of their vulnerability when out of the home visiting a relative. They had been provided with a mobile telephone that had their relative on 'speed dial' so they were easily able to summon support if they needed it. This showed that measures had been put in place to support people to take responsible risks.

We noted that there was no emergency call system in use at the home. We asked the registered manager how people summoned help when they were in their bedroom if they needed it. They told us one person had seizures and an epilepsy alarm had been discussed with the 'epilepsy' team and discounted as unsuitable for this person's specific needs. It had been agreed by the person concerned and the 'epilepsy' team that hourly checks would be carried out during the night instead.

There was a business continuity plan in place that advised staff of the action to take in the event of flood, fire, fuel crisis, a pandemic and loss of utilities. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place that recorded any assistance the person would need to evacuate the premises in the event of an emergency. The PEEP also recorded that people had been shown the safe routes to evacuate the premises.

We saw that any accidents or incidents involving people who lived at the home were recorded. Ten accidents had been recorded since January 2016 although none had resulted in a serious injury. Detailed records of the accident, the resulting injury and any treatment that was needed had been made. However, accidents had not been audited to assess whether any patterns were emerging or whether any further action needed to be taken. The registered manager assured us that this analysis would take place in future.

Only senior staff had responsibility for the administration of medication and training records evidenced that these members of staff had completed appropriate training. In addition to this, personnel records evidenced that the registered manager had carried out competency checks with staff both when they were new in post and then periodically to ensure that they retained the skills they needed to administer medication safely.

Some people were responsible for managing their own medication; this was supported by appropriate risk assessments. People who self-administered medication told us they felt safe to carry out this task.

We observed that medication was appropriately ordered, received, recorded, administered and returned when not used. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Blister packs and medication supplied in boxes or bottles were stored in the medication cupboard, which was locked when not being accessed by staff. We saw that the temperature of the medication cupboard was checked and recorded each morning to ensure that medication was stored at the correct temperature. There was a medication fridge but at the time of this inspection it was not being used, as no-one was prescribed medication that needed to be stored at a low temperature.

We saw that medication, including controlled drugs (CDs), were stored securely. CDs are medicines that require specific storage and recording arrangements. There were three small CD cabinets and medication administration record (MAR) charts recorded whether CDs were stored in cabinet one, two or three. The home's pharmacist had advised the registered manager that one CD that had been prescribed for a person who lived at the home did not need to be recorded in a CD book. This medication had been dispensed in single dose bottles. We saw that this was recorded on the person's MAR chart and two staff had signed the record to show that the CD had been administered. We took advice from our pharmacy inspection team and was told that this CD did need to be recorded in a CD book. The registered manager discussed this again with the home's pharmacist and they acknowledged that their advice had been incorrect, and supplied the home with a CD record book. There was no suggestion that this medication had been administered incorrectly but it had not been recorded as required by the Misuse of Drugs legislation.

Bottles containing liquid medication were dated when the medication started to be used, to ensure it was not used for longer than the recommended period of time. The deputy manager told us that they did not date the packaging on creams and tablets as they never used them for longer than eight weeks. Information leaflets from medicine packages were included in people's care plans so that staff and people who lived at the home had easy access to information about why the medication had been prescribed, any possible side effects and other important information.

We looked at MAR charts and we spoke with senior staff about the safe management of medicines. We found that medication records were clear, complete and accurate, although we discussed that more care needed to be taken to ensure that hand written entries on MAR charts were signed by two people to reduce the risk of errors occurring. The code G on MAR charts was used without explanation; the registered manager told us that this code indicated the person self-medicated and that this would be recorded on the cover of the MAR chart for clarity. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was being audited each week by the deputy manager; this included checks on recording on MAR charts and a check of expiry dates. One person's prescribed medication and associated records were checked thoroughly each week.

On the day of the inspection we observed that there were sufficient numbers of staff on duty. This included the registered manager, two support workers, a domestic assistant and a volunteer. We checked a sample of staff rotas and these evidenced there was always a minimum of two staff on duty; during the night this was

one 'waking' and one 'sleep in' staff member. In addition to this, there was a domestic assistant on duty each day. The registered manager worked full time but over three days a week. There was also a deputy manager employed. People who lived at the home told us that they were happy with staffing levels. Social care professionals told us that there appeared to be enough staff on duty and staff were always visible when they visited the home.

Staff told us they did not use agency staff to cover vacancies, but worked additional hours to cover these shifts between them. They said, "We prefer to use staff who know the service users and who the service users trust."

We checked the recruitment records for a member of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at Lifestyles.

There was a current fire safety certificate in place that included checks on fire extinguishers and emergency lighting, and a portable appliance test certificate. A copy of the gas safety certificate and electrical installation certificate could not be located on the day of the inspection, and a current gas safety certificate was forwarded to us. However, it was identified that there was no current electrical installation certificate in place. This work was carried out on 23 June 2016 and a copy of the certificates were forwarded to us immediately; one for each house (the property was three large terraced houses knocked into one). The certificates recorded that the electrical installation was unsatisfactory. The registered manager told us that this work had been carried out on 4 July 2016 and updated electrical installation certificates were forwarded to us to evidence this.

The previous electrical installation tests at the three properties had been carried out on 23 June 2006 and should have been carried out again in 2011. This work did not take place and although there is evidence that the electrical installation is now safe, in the interim years people were left at risk of harm.

We recommend that the health and safety audits at the home identify when equipment is due to be serviced to ensure people live in safe premises.

Fire drills were carried out each month and these included people who lived at the home and staff. The record for 24 May 2016 showed that two people who lived at the home did not respond to the alarm and that this would be followed up with them by their key worker.

There was evidence that in-house maintenance was being carried out. This included weekly checks on carbon monoxide detectors and the fire alarm system. There was a book that recorded any areas that required maintenance and when this had been carried out. We asked the registered manager if there were window opening restrictors in place and she told us that they had been advised by the health and safety officer of the local authority that these were not required. The registered manager told us that she had discussed this with people who lived at the home and they felt they were being 'treated like children' and some people said they would ask to move elsewhere if they could not open their windows when they wanted to. Following our visit the registered manager took further advice and was told there was no legal requirement for care homes to have window opening restrictors. However, it was recommended that risk

assessments should be carried out, to include consultation with the person's health or social care worker, to identify the level of risk for each individual. In the interim period, the registered manager had arranged to have opening restrictors fitted to all windows in communal areas of the home.

We saw that the home was being maintained in a clean and hygienic condition. An infection control audit had been carried out. This included details of how frequently areas of the home required cleaning and a record of when this work had been carried out, for example, floors were cleaned daily and rugs and lights were cleaned weekly. The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

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 MCA 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. The care plans we saw recorded that the person concerned had the capacity to make their own decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. The registered manager told us that she had not submitted any applications for authorisation. However, on the day of the inspection a review was held for a person who lived at the home. It was agreed at the review that a DoLS application should be submitted in respect of this person. Discussions with the registered manager showed they had an understanding of the need for a DoLS authorisation and of the process to follow.

Care plans referred to a person's capacity in each area they covered. In addition to this, care plans recorded a person's ability to make decisions and any support they might need. We saw that staff spoke with some people, helping them to weigh up the 'pros and cons' of decisions that they needed to make so that they were able to reach the decision themselves. People who lived at the home told us that staff offered them choices whenever possible, and staff said that they made sure people were consenting to any support or care that they provided.

There was a residency rules and agreement plan in place that people had been asked to consent to, and people had consented to self-medicate (when relevant) and to their care and treatment. Some people had completed consent forms that were more specific to their lifestyle, such as consent to extra support being provided with cooking meals.

Staff were issued with a job description which meant they were clear about the role for which they had been employed. There was a training record in place that recorded the topics that were considered to be essential by the registered person. These included health and safety, first aid, medication, infection control, safeguarding vulnerable adults from abuse, food hygiene, MCA and DoLS, fire safety, equality and diversity, learning disability, dementia and challenging behaviour. Most staff had completed this training, and some topics had been completed by all staff. There was a separate record of when refresher training was due; after either one year, two years or three years.

Other training available to staff included the topics of epilepsy awareness, nutrition, risk assessment, moving and handling, professional boundaries, Schizophrenia and bipolar, Huntington's, an introduction to mental health, record keeping and confidentiality and diabetes. We checked the personnel records for one

member of staff and these included training certificates that confirmed mandatory training had been completed. Some staff had also achieved National Vocational Qualification awards.

Personnel records included evidence of induction training and the induction programme documentation had been signed by the registered manager and the member of staff on completion. Both staff who we spoke with told us that their induction period lasted for twelve weeks and that they were an extra staff member on duty for the full twelve week period. The registered manager told us that, in future, new staff would undertake the Care Certificate instead of the existing induction programme. The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life.

Records evidenced that staff had regular supervision meetings with a manager. Topics discussed included the job role, any observations that had taken place during the previous month, policies and procedures, staff praise, achievements and developments, future goals, concerns and complaints and any identified training requirements. We saw that one person's supervision record stated, 'You have settled into a reliable, friendly, trustworthy member of staff. Thank you!' Staff told us that, if the registered manager needed to speak to them about any concerns, this was always done in private. They said, "[The registered manager] never raises her voice. She explains why what we have done is not safe and how to get it right the next time." Another member of staff said that the support they received from the registered manager was "Fantastic. She never dismisses anything – all questions are important."

The daily task list recorded any appointments for the next day and any changes in medication. Staff made daily notes (a cardex system) to record details about how each person had spent their day, such as '[Name] sat watching TV until going for a cigarette and last drinks' and '[Name] told staff he was going out for the day and will be back tonight'. In addition to this, staff used a handover sheet to record information that needed to be passed from one shift to the next. Each person's name was listed on the handover sheet and there was a written entry about each person so that staff were aware of each person's latest support needs and any social activities planned.

We saw that information had been downloaded from various websites about people's medical conditions. One person's care plan included information about the symptoms, cause and prevalence of their condition, which provided helpful information for them and for staff who worked at the home. Care plans recorded details of health and social care professionals who were involved in the person's care. This included psychiatrists, care managers, opticians, community psychiatric nurses and podiatrists. People's care plans also recorded any behaviours that might indicate that they were anxious or becoming unwell so that staff were able to recognise the signs and take action.

We saw that there was a flow chart for staff displayed in the entrance hall in respect of care homes contacting urgent care practitioners. Any contact with health and social care professionals were recorded on the 'cardex' system. This was a daily record of each person's care and support needs and how these had been met. The registered manager told us that any important information was highlighted in pink and this acted as an alert for staff that the person required additional monitoring. Social care professionals told us that the registered manager and staff asked for advice appropriately, and that their advice was followed. One social care professional said, "Staff are good at reporting back on how the advice is working." Another social care professional told us, "I am regularly updated about [name's] well-being."

People's food likes and dislikes were recorded in their care plan, as well as any special dietary requirements. We saw that there were lists in the kitchen that recorded people's likes and dislikes and one person's diet plan, as well as a list of allergens in all of the foods provided at the home. There was a three week menu in

place. There was one main meal of the day and although two choices were not listed on the menu each day, people were aware that they could have an alternative if they did not like the main meal on offer. One person told us, "The food is excellent." Another person told us that they had special dietary requirements and that "They are really good at putting things I need on the [homes] shopping list."

Good

Is the service caring?

Our findings

We saw that one person's care plan recorded, '[Name] is a pleasure to be around and it is an honour to be part of his care and support plan.' People told us that they felt staff cared about them. Comments included, "Staff are brilliant – they are kind", "We seem to live well as a family", "Staff always find time to help me" and "Staff are very encouraging and 'bend over backwards' to help us. [The registered manager] is so nice – all the staff are." A social care professional told us, "I have seen that staff genuinely care. They take time to get to know the person" and another said, "Staff understand people's needs and can answer any queries about them."

One person who lived at the home was away on holiday. They telephoned the registered manager whilst we were at the home to share information about their holiday and to say that they had picked some fruit to share with people who lived at the home on their return. This indicated to us that they felt 'at home' at Lifestyles and 'part of the family'.

Each person had a respect and dignity policy statement in their care plan. People who lived at the home explained to us how they respected each other and how it was important to respect each other's views and lifestyle choices. We saw minutes of a staff meeting that recorded one of the people who lived at the home had requested that staff knock on their door and wait to be invited in, rather than knocking, stating their name and walking in. The minutes of another staff meeting stated, 'Please respect [name's] request for staff to stop taking them breakfast'. This showed that people's views were listened to and that their dignity was respected.

Staff explained to us how they respected a person's privacy and dignity, such as keeping curtains and doors closed when assisting people with personal care and by respecting peoples choices and decisions. One person's representative told us that staff understood the person's functioning and how to support them to have the best quality of life. They said that their well-being had improved since living at the home. They added, "Staff appreciate their needs and their privacy and dignity is respected."

One person worked each day and on their return from work they told us about their day and about their duties at work. Two people told us that they did the shopping on behalf of the home; they got a bus to the supermarket, had a snack whilst they were out and got a taxi for their return journey (paid for by the home). On the day of the inspection one person told us they were going to see their GP and on their return, told us about the appointment. People told us that they completed chores around the home and kept their own rooms tidy, and we saw there was a rota for kitchen duties. Comments from people who lived at the home included, "Staff teach us how to be independent" and "We have freedom to come and go when we want." This showed that people were encouraged to be as independent as possible.

There was a 'morning' meeting each day when information was shared with people who lived at the home, such as 'There's going to be an outing to the railway museum', 'While we are having this sunny spell, please use sun cream to protect yourselves' and 'Staff are arranging a treasure hunt. All welcome. Please meet in the hallway at number 57 at 1.00pm'. These daily meetings were recorded for future reference. In addition to

this, the morning meeting book recorded the names of the staff on duty and any announcements, such as new information about a person who lived at the home and changes to a person's medication; all staff were required to sign the record to evidence they had read it. This information cross referenced with the staff handover records and the meeting minutes.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. People told us that they were able to follow their chosen religion. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

We were told that one person had an advocate that they used when they were distressed and that the person concerned 'trusted' their advocate. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Good

Is the service responsive?

Our findings

At the front of each care plan there was a statement that recorded, 'This is all about me. I am proud of my care plan'. People had been offered a copy of their care plan to hold in their bedroom, and care plans recorded whether the person had accepted or declined this offer. One person told us, "I can read my care plan at any time, and I've been involved in a full review" and one person's care plan recorded, 'I was invited to take part in updating my care plan today'. Care plans also included a description of person-centred care to help staff and people who lived at the home to understand this terminology.

We saw that care needs assessments included information about what the person enjoyed, their general health, their hobbies and interests, where they had previously lived, their family contacts, their education, their social life and their personality.

The care plan produced by the local NHS Trust, assessment information and risk assessment information had been incorporated into an individual plan of care. We saw that these were individual to the person concerned and covered areas such as practical jokes, taking complaints seriously, taking things without consent, healthy eating, money management and spending, food and cooking, and 'a structure day to day'. We noted that one person's care plan recorded important information about their general health at the back of their file. We discussed how this might not be clear for staff and the registered manager moved this information to the front of the person's care plan immediately.

Care plans recorded people's skills and abilities such as their ability to use public transport, their road safety and their ability to use the kitchen as well as the level of support they required in some areas of their lives. People were encouraged to develop skills and they were issued with certificates of achievement when they had reached their goals. We also noted that some people who lived at the home attended training courses along with staff; we saw five health and safety training certificates awarded to people who lived at the home displayed in the entrance hall. People who lived at the home told us about the training courses they had attended, such as literacy and numeracy and cookery.

We saw that each care plan included a statement saying, 'Designated staff must review with the service user every eight weeks and make sure all is agreed and signed'. Although we did not see any formal care plan audits, we noted that care plans were reviewed by staff on a regular basis to ensure they remained relevant.

People who lived at the home were encouraged to be part of the local community. People told us they went to the pub to watch football when England were playing, that they belonged to a pool team and a dominoes league and one person went to see all of the York City football matches, both home and away.

People told us that there were some rules, such as respecting each other's space, not smoking in bedrooms and not using the patio after 11.30 pm as some people "needed their sleep". One person told us, "We can go out when we like – we sign out and let staff know when we are back."

We saw that people's bedrooms reflected their interests and their personality. There was a coin box

telephone so that people were able to keep in touch with family and friends. One person told us, "All of my family have been welcomed here."

Each care plan included a complaints form ready for use, along with an envelope addressed to the registered manager. The complaints procedure was clearly displayed in the home and again, there was a complaints form and an envelope addressed to the registered manager ready for use. The registered manager told us that there had been no complaints (formal or informal) made to the home in the last twelve months. Complaints were discussed at each annual review so that people had a formal opportunity to express concerns or make complaints. The registered manager said that people who lived at the home had direct telephone numbers for their care manager in case they had queries or concerns. People told us that they knew how to complain and that there was a complaints form in the entrance hall that they could fill in.

People told us that they also received surveys that gave them an opportunity to give feedback on the support they received. One person said, "We've completed surveys for example on bedrooms. One is due out soon" and another told us, "We complete two surveys a year. We can make comments. Any feedback would be on a private basis." One person recorded in a survey, "Since I have lived at Lifestyles my whole life has changed."

We reviewed the report produced by the local authority when they had carried out a monitoring visit to the home. The report was very positive although they had suggested that meetings should be held for people who lived at the home. These were not taking place and people who lived at the home told us they did not need to have meetings, as the registered manager and staff were available whenever they needed to speak with them. One person said, "You can approach [the registered manager] anytime about a problem."

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

The registered manager had completed training on leadership, mental health at an advanced level, assessing the Care Certificate and cognitive behaviour therapy (CBT) as well as other training alongside the staff group. This meant they had kept up to date with good practice guidance, and there was evidence that this had been shared with staff.

People told us that the home was well managed. Social care professionals told us that "Things at the home have improved under the new management." They said that the registered manager was "Good at promoting service user rights." One social care professional mentioned that, because the registered manager and deputy manager were skilled and 'hands on' there was a risk that staff relied on them too heavily rather than making decisions for themselves. However, all social care professionals told us that staff at the home were able to support people who had complex needs. One health care professional recorded in a survey, "Since [the registered manager] has taken over the house seems to be much cleaner and a happier place to live."

A person who lived at the home told us, "Since [the registered manager] has taken over the house has got better. There have been lots of changes and all for the better." Another person who lived at the home recorded in a survey, "[The registered manager] is a very special person and has a special way of listening to us. I've been in care all my life and this is the first time ever that I felt valued"

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. We saw that there was guidance for staff on how to submit notifications to the CQC so that they were able to carry out this task in the absence of the registered manager. The registered manager had informed CQC of significant events such as serious injuries which meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

We saw that care plans recorded the vision (culture) of the home. This included the statement, 'Humility, simplicity, empathy, compassion, patience and above all respect for a unique individual.' It was clear that these had been adopted by people who lived at the home and staff, as we heard the value of respect being discussed and demonstrated by people throughout the day. We asked staff to describe the culture of the home and they told us, "[The home] is caring and homely with good relationships. Coming to work is like coming to a family home", "Unique" and "Independent living skills are encouraged."

Staff told us that they attended monthly staff meetings. They said information was shared with them and they could also express their views. The minutes of each meeting included an overview of the previous staff meeting. Discussion points included new members of staff, safeguarding policies and procedures, medication, the maintenance record book, effective recording, use of mobile telephones, room checks, team building and tidiness.

We saw there was information for staff displayed in the hallway including the infection control code of practice, the fire risk assessment, information about Deprivation of Liberty Safeguards (DoLS), information from a recent safeguarding conference, the National Institute for Health and Care Excellence (NICE) guidelines in respect of younger adults, the CQC equality objectives and information about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

We saw the outcome of surveys that had been completed by health and social care professionals and all of the comments were positive. One professional commented, "I find Lifestyles warm, welcoming with wonderful staff and residents. All residents are well cared for and staff go above and beyond the call of duty. It is one of the better homes I have visited."

The director of the company carried out inspections. We saw the report from February / April 2016 recorded that they had spoken to people who lived at the home and had looked at records including feedback from surveys. They stated that they were very satisfied with progress in the home and with the updated care plans.

The local authority had carried out a review of the home in January 2016. We checked the report and found that most comments were positive. There were numerous recommendations made about minor improvements that were needed to the service, and the report recorded the action that had been taken by the registered manager to make the suggested improvements.