Leonard Cheshire Disability

Appley Cliff - Care Home Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 10 May 2016 and was unannounced. Appley Cliff provides accommodation and personal care for up to 13 people who have a physical disability. There were 12 people living at the home when we visited.

There was a registered manager at the home. 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.

With the exception of prescribed topical creams medicines were managed safely and people received these as prescribed.

Appley Cliff had a strong, person centred culture. People were supported and encouraged to be as independent as possible and able to live the lifestyle they chose. Staff and management were fully committed to finding ways to improve the service.

People and external health professionals were positive about the service people received. They praised the staff and care provided. People were also positive about meals and the support they received to ensure they had a nutritious diet.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. People had access to healthcare services and were referred to doctors and specialists when needed. Reviews of care involving people were conducted regularly. People were supported to enjoy activities of their choosing.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly. People's ability to make decisions had been recorded appropriately, in a way that showed the principles of the Mental Capacity Act (MCA) had been complied with. Staff offered people choices and respected their decisions appropriately.

The Deprivation of Liberty Safeguards (DoLS) were applied correctly. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

There were enough staff to meet people's needs. Contingency arrangements were in place to ensure staffing levels remained safe. The recruitment process helped ensure staff were suitable for their role. Staff received

appropriate training and were supported in their work.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals. Staff worked well together which created a relaxed and happy atmosphere, which was reflected in people's care.

The registered manager and provider's representatives were aware of key strengths and areas for development of the service and there were continuing plans for the improvement of the environment. Quality assurance systems were in place using formal audits and regular contact by the provider and registered manager with people, relatives and staff.

We have made a recommendation about the management of prescribed topical creams.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was usually safe.

With the exception of prescribed topical creams people received their medicines at the right time and in the right way to meet their needs.

People felt they were safe and staff were aware of their responsibilities to safeguard people. Risks had been assessed individually and action taken to ensure people's safety without placing unnecessary restrictions on them.

Recruitment procedures included relevant checks on new staff to keep people safe. There were enough staff to meet people's needs and arrangements were in place to manage emergency situations.

Is the service effective?

Good

The service was effective.

People's rights and freedom were protected. The provider and care staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS).

People were supported to have enough to eat and drink. Their health and well-being were monitored effectively and they were supported to have their medical needs met.

Staff received appropriate training and support to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Appley Cliff had a strong, visible person centred culture. People were encouraged to be as independent as possible and able to live the life they choose.

Interactions between people and staff were all positive and

showed staff valued people as individuals. Staff spoke positively of the people they cared for and treated them with kindness and compassion. People's privacy and dignity were respected and confidential information was kept securely.

People were involved in assessing, planning and agreeing the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

Staff were responsive to people's needs. People were supported to make choices and retain their independence.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy. The registered manager sought and acted on feedback from people.

Is the service well-led?

Good

The service was well led

There was an open and transparent culture within the home. The registered manager was approachable and people felt the home was run well. Staff understood their roles and were happy in their work.

Quality assurance systems were in place using formal audits and regular contact by the registered manager and provider's area manager with people, relatives and staff. Policies and procedures had been reviewed and were available for staff.

Appley Cliff - Care Home Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection took place on 10 May 2016 and was unannounced. The inspection was undertaken by one inspector and an expert by experience in the care of people with a physical disability.

We reviewed information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. Before the inspection, the registered manager 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 spoke with six people living at Appley Cliff. We observed care and staff interactions with people in communal areas. We spoke with the registered manager and four care staff on duty. We also spoke with two health care professionals who had regular involvement with the service. We looked at care plans and associated records for four people, staff duty records, staff recruitment and training files, records of accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People received most of their medicines safely. However, systems did not ensure that prescribed topical creams were applied correctly. Staff were not recording the date that topical creams were first opened which meant they could be used beyond the safe to use date. Topical creams administration records were in use but these did not show that staff were applying topical creams as prescribed. For example, one person was prescribed a topical cream which should be applied twice a day and this had not occurred. Another topical cream found in a person's bedroom had no date of opening and the application record showed this had not been applied since November 2015. We also found a prescribed topical cream in a person's bedroom that did not have a topical cream application chart. When asked staff were not clear about which topical creams were in use for some people or where these should be applied. For one person there was a container of prescribed topical cream which staff stated was no longer in use. The pharmacy label was so faded and worn that it could not be read and therefore we could not see who this had been prescribed for or when it was dispensed by the pharmacist. Staff stated that this had occurred as the container had been left in direct sunlight. The topical cream stated it should be stored below 25 degrees and it is likely to have been exposed to a higher temperature in direct sunlight. Staff were aware that topical creams should not be used if opened for a prolonged period but could not explain why they were not recording when creams were first opened. The provider's medicines policy in use by staff did not include reference to how prescribed topical creams should be managed.

We recommend that the service considers current guidance on the management of prescribed topical creams and takes action to update their practice accordingly.

People told us they received their medicines from staff and that they could request 'as required' medicines, such as paracetamol for a headache if needed. Medicines were administered by staff who had received appropriate training. We observed staff administering medicines and the procedure used ensured the safe administration of medicines. There was detailed individual information about how people should be supported with their medicines. For example, for one person this directed staff to place their medicine onto a spoon with a small amount of food as they found this the easiest way to swallow tablets. The person's care plan showed their GP had been consulted and was in agreement that it was safe for the medicines to be given with a small amount of food. Another person was managing their own medicines. Staff had completed a risk assessment and were checking the person's stock levels weekly to monitor that they were taking the medicines as prescribed.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines were prescribed to a person and when they were given. Medicines were stored securely according to the manufacturer's instructions and there was an appropriate process for the ordering of repeat prescriptions and disposal of unwanted medicines. In one person's daily records we saw how staff had taken action to obtain medicines for a person which had been 'running low'. There were auditing and checking procedures to ensure people received their medicines. We saw how this had identified that staff had failed to give a person a medicine. Appropriate action was taken including seeking medical advice and an investigation by the registered manager to identify how this error occurred. A stock monitoring system

was in place for all boxed medicines which would help identify errors or non-administration and also ensured stocks were requested when supplies were required.

The process used to recruit staff helped ensure staff were suitable for their role. A full work history and confirmation of the applicant's identity were available. However, where applicants had stated they had breaks between previous jobs there was not always an explanation as to the reason for these. Those successful at interview undertook a criminal history check and two references, including from their previous employer, were sought. People were involved in the interviews for new staff. We saw within recruitment records the forms completed by people to show involvement and views about the applicants. A newer staff member confirmed the recruitment process and checks had been completed prior to them commencing employment.

People told us there were enough staff during the day and night and our observations indicated this was the case and there were sufficient staff to respond to the needs of people. One person told us the response times to call bells was "usually very quick". Staffing levels were determined by the provider and registered manager who assessed people's needs and took account of feedback from people and staff. The registered manager said that part of the assessment for a new admission involved determining the amount of staff that would be required to ensure the person's needs would be met. They added that this was also considered at reviews. The registered manager stated they had flexibility as to how staffing hours were used. They gave an example of how they had used staffing hours to ensure appointments were covered or support people to attend evening activities.

The home had a small number of bank staff who covered extra shifts when required and the home's regular staff told us they also covered some additional shifts. Agency staff had not been required although the registered manager told us they were meeting with an agency representative as they felt it would be good to have the option in place should it ever be required. Duty rosters showed that staff covered additional shifts when necessary ensuring staffing levels were maintained at a safe level. In addition to care staff, ancillary staff such as the administrator, driver, chef and housekeeping staff were employed. The registered manager was not included in staffing numbers and the head of care had dedicated time to meet their responsibilities. A staff member said, "There are enough staff, some days it's busier but not too bad". Another staff member said, "Obviously if we had more staff we could spend more time on activities or talking with people but generally there are enough staff". We saw staff had time to spend with people informally chatting and that at no time were people rushed or hurried by the care staff.

Risk assessments were relevant to the person and actions required to reduce the risk had been completed. These included the risk of people falling, nutrition, smoking and support with moving around the home or the community. Risk assessments were used to identify the risk and consider what action was required to ensure the person was able to enjoy the lifestyle they wanted and not restrict them unnecessarily. Therefore some risks remained such as those related to people making choices about going out on their own or mobilising independently within the home. People were involved in their risk assessments and had signed to confirm their involvement and agreement with planned actions to reduce risks. One person told us how they had recently fallen from their wheelchair having made their own decision not to wear a seat belt "despite staff telling me I should always wear one". Where people had fallen, assessments were completed of all known risk factors and additional measures put in place to protect them where necessary. We observed equipment, such as pressure relieving devices and repositioning equipment, being used safely and in accordance with people's risk assessments. Risk assessments had been regularly reviewed and were individualised to each person. These helped ensure people were safe from avoidable harm.

Environmental risks were managed appropriately although the first floor fire exit was not fitted with an

alarm to alert staff that the door had been opened. The registered manager acknowledged a risk existed and stated they would arrange for the door to be fitted with an alarm. The provider produced a range of environmental risk assessments which the registered manager stated they were able to individualise to the home. Records showed essential checks on the environment such as fire detection, gas, water and electric supplies and equipment, were regularly serviced and safe for use.

The registered manager was aware of safeguarding and what action they should take if they had any concerns or concerns were passed to them. There were appropriate policies and procedures in place to protect people from abuse. Staff had received training in safeguarding adults and knew how to identify and report abuse, and how to contact external organisations for support if needed. Contact details including phone numbers were available in the main and care staff offices. Staff said they would have no hesitation in reporting abuse and were confident the provider would act on their concerns. One staff member told us, "We all do safeguarding training and I would report any concerns to [the registered manager] or social services".

There were plans in place to deal with foreseeable emergencies. Everyone we spoke with told us about the weekly fire alarm practices and were well aware of the evacuation procedures. Personal evacuation plans were available and signed by all people showing these had been discussed with them. These included individual details of the support each person would need if they had to be evacuated. We were also told about a night time fire drill which had taken place. Staff had undertaken first aid and fire awareness training. They were aware of the action they should take in emergency situations. Systems were in place to ensure fire detection and fire safety equipment was regularly checked to ensure it should function correctly if required. Records viewed confirmed these checks were completed.

Good

Is the service effective?

Our findings

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Everyone living at Appley Cliff was able to make day to day and most other decisions on their own and this was reflected in their care plans. One person's care records contained conflicting information. It stated that the person could make their own decisions and also that a relative had the legal authority to make decisions on their behalf and had signed the care plan. The registered manager said they would look into who could legally make decisions, or which decisions, on behalf of the person. Care plans contained detailed individual information showing how people could be supported to make decisions including information about the best time of day for people to make a decision and how information should be provided to them.

Staff showed an understanding of consent. Before providing care, we observed they sought consent from people using simple questions and gave them time to respond. One staff member said, "If a person says that they don't want care at that time then we leave them and go back later". Care records contained various consent forms signed by the person including data protection, sharing of medical information and photographs and included other relevant information about people's abilities to consent to care. One person's health care plan stated "I have capacity to consent to treatment'. Daily records included information showing people felt able to refuse offered care and this was respected by care staff.

People were free to come and go as they liked. A person said, "I can go out whenever I want". No-one living at the home was subject to any legal restrictions. The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were able to give clear accounts of the meaning of Deprivation of Liberty Safeguards and how these might affect people in their care. The registered manager was aware of when and how to make DoLs applications to the local authority.

People were able to access healthcare services and received the personal care they required. Everyone we spoke with told us they could see a doctor or other healthcare professionals when needed. Several people commented that when required staff took prompt action to arrange GP visits. One person told us they had "seen the optician" and "the chiropodist comes every couple of months". People also told us about a local chiropodist and that they were taken there in the home's transport by a staff member. We saw a person was supported by staff and the home's transport to attend a local dentist.

Care records contained information about people's previous known healthcare needs and treatment and

what support they required with ongoing medical needs. Care records also showed people were referred to GPs, opticians, community nurses and other specialists when changes in their health were identified. We also saw that when required emergency treatment was sought for people or in less urgent situations staff sought guidance from the 111 service. Discussions with the registered manager showed they were aware of how to access medical advice and when this may be required. For example, records showed staff had sought Speech and Language Therapist (SaLT) guidance in March 2016 and also appropriately requested a wheelchair review assessment. Care records contained 'hospital passports' which provided hospital staff with relevant information they would require if a person was admitted to hospital. Two visiting health care professionals said they had a positive relationship with staff and their recommendations and guidance were followed. They added that they were contacted appropriately and in a timely way when required.

A person said they felt the care they received was good and their needs were met well. People were observed to be appropriately dressed and with attention to hair and nails. People received the level of support they needed but were encouraged to be as independent as possible to maintain current skills. Care staff were able to describe the support people required. Care files included information about personal care and general health care needs and the support individual people required to ensure these needs were met. Care records recorded the personal care people received. The information recorded included repositioning (where required) and the provision of personal and continence care. These records had been completed fully and demonstrated people were receiving personal care. Where people had specific health needs such as epilepsy there was specific guidance for staff as to how to support the person appropriately. Care plan records showed staff had 'chased up' blood test results for a person and for another person had noted changes in a person's skin and requested visiting district nurses' advice.

Everyone was complementary about the meals provided. One person told us, "The food is very good. I get the food I like". We were told the menus changed weekly and everyone was consulted as to their favourite dishes which were then included in planned menus. We observed the lunch time meal which was a relaxed, informal, social occasion. People were supported to the dining room and able to sit with people they enjoyed sitting with. People were observed to eat their meals and appeared to enjoy them.

People received appropriate support to eat and drink enough. Where needed, staff encouraged and assisted people to eat their meals. They did not rush people and spoke with them throughout the meal. Choices were provided in a way that encouraged people to make decisions and care staff were aware of people's preferences and dietary needs, which were met. Alternatives were offered if people did not like the menu options of the day. The chef told us all meals were made from fresh ingredients and they were aware of any special dietary needs such as a person who was diabetic and others who needed their meals in a soft or pureed texture. The chef stated they were happy to be flexible and would serve food later if requested and always catered for anyone who changed their mind about what they had chosen. Daily notes recorded people had received a cooked breakfast and that other people were provided with drinks and snacks such as sandwiches at all hours of the day and night whenever they requested these. Drinks were available throughout the day and staff prompted and supported people to drink often.

People told us they liked their bedrooms and the communal areas of the home. The environment was safe and adaptations had been made to make it suitable for the people living there. Adaptations included assisted bathing and showering facilities and wider corridors and doorways to allow easy access for wheelchairs. The majority of the bedrooms were on the ground floor with several on the first floor accessed by a lift which people could operate on their own. There was a lounge, activities room and separate dining room which were decorated and furnished in a homely style. There was level access to the enclosed rear garden which was flat and had pathways suitable for people to use. A conservatory was available for people who wished to smoke cigarettes. The front door was self-opening enabling people free egress and entrance

throughout the day. Bedrooms were personalised with items important to their occupants and included all necessary aids to independence and mobility such as ceiling hoists.

Staff were knowledgeable about the needs of people and how to care for them effectively. When asked if they felt staff had a good understanding of their needs one person said "The staff are very good on the whole". New staff received induction training which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Records showed staff were up to date with essential and service specific training and this was refreshed regularly. A senior member of care staff was a moving and handling trainer meaning they could provide practical training geared specifically to the needs of the people living at the home. Most staff had obtained recognised care qualifications relevant to their role or were working towards these.

People were cared for by staff who were motivated and supported to work to a high standard. A person said "The attitude of the staff is brilliant, they all work very hard". Staff were supported appropriately in their role, felt valued and received regular formal and informal supervision. One staff member told us, "There is always a senior staff member available either in the home or on call if we need advice or help." This was confirmed by other staff we spoke with. The head of care worked with care staff providing an opportunity to observe them providing care. Formal supervisions, which provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs, occurred every two months. Each staff member was allocated to a senior staff member for supervision with the registered manager supervising the senior staff. The registered manager told us they viewed completed supervision records to ensure these had been completed to an appropriate standard and identify if there were any concerns or trends being raised by staff.

Good

Is the service caring?

Our findings

Everyone we spoke with said staff treated them in a very caring way. One person told us "The staff are very patient ". A second person said of the staff, "Everyone's very friendly". Another person told us "The routine is good, not regimented; it gives me so much freedom". People said there was a consistent staff team who they had got to know. One person described how staff had been "happy that they were safe" after an accident when out alone which had resulted in minor cuts and bruises. This showed people felt staff cared about them. The atmosphere at Appley Cliff was calm, friendly and relaxed. There was easy and friendly communication between staff and people with the use of first names. One person told us they would often request a sandwich at various times of the day and night showing they were confident to make requests of staff.

Staff treated people with kindness and consideration. For example, when a person returned home staff were heard to say "Oh [person's name] your back; you must have smelt the kettle boiling". To which the person replied, "Oh good, I need one". Care staff then expressed sympathy for the treatment the person had had at the dentist and asked how they were feeling. Throughout the inspection we heard lots of banter between people and staff which showed staff knew people well and that people were relaxed with staff. All members of staff spoke positively about people and knew them as individuals. Staff were able to tell us about things which mattered to people. The registered manager described how they made sure people received a caring service. They said they spoke with people to gain their views and by observations and demonstration, treating people as they would want staff to treat people. The registered manager also used staff meetings, supervisions and appraisals to promote a caring service.

Staff understood people's individual needs. One person said the staff "know me and what I like". Due to the size of the home and staff team people were cared for by staff who worked with them frequently and knew them as an individual. For example, care files included a section 'what makes a good day for me'. This detailed individual people's preferences for what time they liked to get up, how they liked to spend their day and other important matters for the person. Staff offered people choices, such as to where to sit in the lounge or dining room. When necessary staff knelt down to make eye contact with people to ensure they were listening when asking them questions.

People were encouraged to be as independent as possible. A person said they were given any help they need but had privacy to wash themselves as they did not need help with this. At meal times we saw assistance was given only when required. People were facilitated to eat independently and were provided with equipment to facilitate this. For example, one person was provided with a plate with a rim and another person had adapted cutlery to enable them to eat independently. Care plans focused on what each person could do and then what they required assistance with. For example, one stated '[person's name] can wash own face and hands, clean own teeth and brush hair' before identifying what the person required help with and how this should be provided.

People were involved in planning their own care. When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they needed. People's

preferences, likes and dislikes were known. Care files contained individual information about personal preferences such as those around food and drinks. Support was provided in accordance with people's wishes. People told us they could remain in bed as long as they liked and spend time where they liked in the home. Daily records of care provided confirmed that people's preferences as detailed in care plans were met. We saw some people choose to remain in their bedrooms and others spent time in communal rooms.

Staff ensured people's privacy was protected by speaking quietly and ensuring doors were closed when providing personal care. All bedrooms were for single occupancy. People stated that staff ensured their privacy at all times and they had not witnessed any concerns with privacy or respect from staff interactions with other people. A person said that nearly all staff knocked on their room door before entering. People told us they could receive personal care from staff of a preferred gender. Information about people's preferences such as preferred gender of staff for personal care was included within care plans. Care plans also contained information about who the person was happy for their personal information to be shared with. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them. One person had requested for their records to be kept in their room. This was stated in their care plan and we confirmed with them that this was where the records were kept.

People were encouraged to express their views both formally and informally. Meetings were held with people. The minutes of these showed topics such as menus and activities were discussed. Meetings were also used to keep people informed about important events. For example, minutes recorded that people were told about planned work on the building. Where something was identified during a meeting we saw that action was taken to address the issue. For example, action was taken when it was raised about people smoking at the front of the home meaning other people had no choice but to enter through a smoky area. As a consequence people were now able to smoke in a conservatory at the rear of the building and there were plans to build a smoking shelter at rear of the home. A list of planned resident meetings was available on a notice board so people would be aware when these were due to take place. This meant everyone had the opportunity to express their views and for these to be considered. The provider had a personalisation and involvement officer who visited the home every three months to talk with people. The personalisation and involvement officer was also available to people at other times by email and phone.

We observed staff asking people informally for their views about day to day decisions such as what film to put on the television and if they had enjoyed their meal. This encouraged people to express their views and helped people retain control over their lives. There was information about local clubs, events and organisations which may be of interest to people. This meant people could continue to take part in their local community as they wished. People told us they could have visitors whenever they wanted and were supported to maintain links with their family and friends. For example, one person's daily notes recorded that a person had requested support to write a letter to a relative which staff had then ensured was posted for the person.

Good

Is the service responsive?

Our findings

People received personalised care from staff who understood and met their needs well. Everyone we spoke with felt all staff knew them very well and responded to any changing needs effectively. Two external health professionals were complimentary about the way the service responded to people's changing health needs. They told us staff would contact them appropriately and had the necessary skills and knowledge to meet people's needs.

There was a formal pre-admission process to ensure only people whose needs could be met were admitted to Appley Cliff. The assessment covered all necessary areas and showed there was further discussion with the person and, where appropriate, any relatives. Documentation showed there was also contact with the person's social worker and a clear agreement about how the person would be supported including individual funding, level of staff support and any equipment required. The registered manager was clear about the level of need the home could meet. They said that if a prospective admission identified that a person would require a secure environment this could not be provided as it would impact too much on people already living at the home who were able to come and go as they pleased. The comprehensive approach to admissions helped ensure people already living at Appley Cliff were not placed at risk by unsuitable new admissions whose needs could not be met.

Staff were responsive to people's needs. We saw in one care record that staff had identified a person was developing some sore areas of skin. Staff had noted this, sought medical advice and supported the person to follow the district nurse's guidance. All staff received a formal handover at the start of each shift which kept them up to date with any changes in people's needs. We saw people being supported as described in their care plans. Records of daily care confirmed people had received care in a personalised way in accordance with their care plans, individual needs and wishes. Care files were reviewed six monthly or when needs changed. Reviews and amendments had been signed by the person whose plan it was to show they had been discussed and agreed.

Care plans provided comprehensive information about how people wished to receive care and support. Individual care plans were well organised, person centred and the guidance and information for staff within them was very detailed. It was evident that each person had been included in the formation of their care and support plans. Care plans included information about what was important to the person, and things staff needed to know or do to support them. This included people's likes and dislikes and goals for the future. For example, one person wanted to try lace making and to study for an A level in English. Care plans were typed making them legible and hand written additions had been added showing that they were live documents and people could amend their preferences or needs at any time.

When people had been identified as having a care need there was information about contact with external professionals and clear guidance for staff about how the person should be supported. For example, one person was at risk of choking and required a soft diet. There was guidance from the Speech and language Therapist about the diet and how the person's preference for a cheese sandwich could be accommodated if crusts were cut off and lots of butter were used. Care plans also included specific individual information to

ensure medical needs were responded to in a timely way.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the necessary care. Incidents and accidents were recorded. Forms viewed showed that, where necessary, external medical advice was sought and action was taken to monitor the person for any signs of deterioration. Action was taken to reduce the risk of repeat incidents without overly restricting the person's freedom and independence.

People enjoyed a range of activities suited to their individual needs and interests. One person told us they were taken to the local town in the home's transport every week to go shopping or to the hairdresser. Another person said there were regular trips out which were decided by people. These included places like cinemas, football matches and several people had been on holiday to Lille, Belgium for a few days. The home had transport suited to the needs of people and employed a driver who was available for social activities when not required to take people for medical appointments. Where necessary people had their own powered wheelchairs or mobility scooters. These made it easier for care staff to assist people when out as they did not have to manually push wheelchairs up or down hills. Wi-Fi internet access was available in all areas of the home. Volunteers supported people with activities in and out of the home. They were organised by a paid volunteer coordinator who was responsible for making sure volunteers received any necessary training. They described how care was taken to match volunteers to people, considering personalities and what the person wanted from the volunteer. They said they were trying to identify a volunteer with lace making skills which showed they were aware of people's specific requests and interests. The interests, hobbies and backgrounds of people were recorded in their care plans. The registered manager described how they were trying to recruit an activities organiser and that they were using some bank staff hours to provide activities until the post was filled.

People knew how to complain or make comments about the service and the complaints procedure was prominently displayed. All people said they would talk to their key carer or the registered manager if they were unhappy about anything happening in the home. One person told us they had been able to bring up a concern they had had about another person and this was settled in a satisfactory way. The admissions checklist included ensuring that people had been provided with information about how to complain. Information about how to complain was also seen on a communal notice board. Complaints were recorded formally on the provider's computer system and linked to monthly quality assurance processes. Records showed complaints were dealt with promptly and investigated in accordance with the provider's policy.

There were monthly meetings with people to seek feedback about the service. The provider also sent surveys to people on a regular basis. These were analysed and where necessary action taken to respond to any issues raised. The analysis of the most recent survey showed people were very satisfied with the service they were receiving. Everyone responded that they were happy with the way they were involved in developing and reviewing their support plan and that it was easy to make changes if required. Everyone also stated in the survey that they were satisfied with the care they received.

Good

Is the service well-led?

Our findings

People liked living at Appley Cliff and felt it was well-led. One person said, "I like the way things are run". Another person said "Basically I'm happy here but I miss being at home". And a third person said "I love it here, the routine, it's a very relaxed way of life". An external health professional told us, "Appley Cliff is run well. We have a good working relationship with the manager and staff."

There was a clear management structure in place consisting of a registered manager, a head of care and senior care staff who had individual responsibilities. Staff enjoyed working at the home and told us they felt supported by management. Staff also said the atmosphere was relaxed and staff relationships were good.

The registered manager described the home's values as being "to provide an individual, personalised service". They also spoke about choices, independence and respect. Staff told us the home's values were to provide person centred, individual, good care. A staff member said "It's their home; we should treat everyone with respect". Another staff member said it was important that "people who live here should feel valued and treated like this is their home, not our work place". Staff also spoke about respecting people's choices and freedoms. Staff said they would be happy for a member of their own family to receive care at Appley Cliff.

There was an open and transparent culture within the home. Visitors were welcomed, there were good working relationships with external professionals and the registered manager notified CQC of all significant events. The registered manager had been employed at Appley Cliff since January 2016 and had registered with the commission. There was a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. Where possible people were supported to attend appointments at the local health centre or use community health facilities such as dentists and chiropodists. Volunteers were recruited from the local community and people were provided with information and supported to attend local community events. Appley Cliff had held a Summer fete in 2015 to which the local community had been invited and had held a coffee morning in the nearby town.

The registered manager told us they received appropriate support from the provider. They said they had a clear budget and were able to make decisions about spending. For example, they described how they had struggled to recruit an activities organiser. They had reviewed budgets and were in the process of making an application to the provider to increase the amount they would pay to attract suitable applicants. The provider's area manager visited the home every two months and produced a report of their visits to the registered manager. Where necessary these included actions required which were reviewed at their next visit.

Auditing of key aspects of the service, such as care planning, the environment, medicines and infection control were effective. Where changes were needed, action plans were developed and changes made; the plans were then monitored to ensure they were completed promptly. For example, in April 2016 the registered manager had identified some care plans needed updating. There had been discussion with staff

and action was being taken to update the identified care plans. The provider's quality assurance system included monthly reports by the registered manager and assessment by provider's quality review team. The registered manager provided a monthly report to the area manager covering aspects of the service including any staffing changes, admissions, complaints, accidents and incidents. In addition the registered manager and the care supervisor spent time working with staff and observing care being delivered to help ensure staff worked effectively. Specific areas of the service were audited by people within the provider's team with the necessary skills. For example, an annual health and safety audit was completed by the provider's estates team.

The registered manager was aware of key strengths and areas for improvement at the home and there was a plan in place to manage these. This included enhancing the environment and developing the garden for the benefit of people. This included redecoration and making an upstairs shower room as it had been identified that people preferred showers to baths and at present had to come downstairs to access a shower. The improvements would also include an upstairs sluice meaning staff would not need to bring items downstairs if a sluice was required.

The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the care office. We were told policies were reviewed by the registered manager yearly or when changes were required. This ensured that staff had access to appropriate and up to date information about how the service should be run.