West Sussex County Council

Tozer House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 8 March 2017 and was an unannounced inspection.

At the last inspection, in January and February 2016, the service was rated 'Requires improvement'. At this inspection, we found the service had made improvements. The three breaches of regulation concerning medicines management, quality assurance and the sending of key notifications to the Commission had been met.

Tozer House is a residential care home that provides support to a maximum of 15 people who have a range of learning disabilities and some who were living with dementia. The home comprises two houses, Rosemead and Bramley, where people live and a third building with the communal dining area and offices. The buildings are situated around a garden area. The home is located within walking distance of Chichester town centre. At the time of this inspection there were 12 people living there, some on a temporary basis.

The service had a new registered manager. They started in post in October 2016 and were registered with the Commission in December 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider and registered manager had overseen improvement at the service. There were systems in place to monitor the quality of the service delivery and to drive improvement. Action plans were in place and monitored to ensure that necessary changes were implemented. Records relating to staff training and supervision were in place and up-to-date.

Medicines were managed safely. New systems were in place to ensure that people received their medicines as prescribed. Staff who administered medicines had received training and their competency was assessed. Systems were in place to monitor the administration of medicines and to pick up any omissions or concerns.

The registered manager had notified the Commission of important events as required by law. We discussed the various notifications that services are required to send to the Commission. The registered manager demonstrated a clear understanding of her responsibilities in this area.

Feedback from people, relatives and staff about the service was very positive. People told us they felt safe, that they enjoyed support and friendship from a regular staff team and that they were regularly asked for their views and opinions. Staff felt supported and told us their ideas and opinions were valued by the management team.

People told us staff treated them respectfully and said there were enough staff on duty to assist them. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they

were concerned that someone was at risk of abuse. Risks to people's safety were assessed and reviewed.

People had developed good relationships with staff and had confidence in their skills and abilities. There was an established team of staff at the home, which offered continuity of care for people. Staff had received training and were supported by the management through supervision. Staff were able to pursue additional training which helped them to improve the care they provided to people.

People enjoyed a variety of home-cooked food. Staff were aware of people's dietary needs and preferences and adapted the menu accordingly.

People were involved in planning their care and staff understood what was important to them. Each person had a keyworker who took the lead in supporting them and coordinating their care.

Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff supported people to be as independent as they were able and to pursue their hobbies and interests. People received one to one time to develop their independent living skills, including managing finances, cooking, laundry and accessing the community.

Staff responded to changes in people's needs and adapted care and support to suit them. Where appropriate, referrals were made to healthcare professionals such as the GP or chiropodist and their advice followed.

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.

People received their medicines safely.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

There were enough staff to meet people's needs and keep them safe.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles. They were supported through regular supervision.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received individualised care from staff who cared and who knew them well.

People were involved in making decisions relating to their care and were supported to be as independent as they were able.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's care was planned and monitored to promote good health.

Staff understood how to support people and responded quickly to any changes in their health.

People were encouraged and supported to spend their time and engage in pursuits that interested them.

People knew how to make a complaint if necessary and were confident any issue would be addressed.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager. Staff told us they were listened to and felt valued.

The registered manager and provider used a series of audits to monitor the delivery of care that people received, to ensure that it was consistently of a good standard and to make improvements.

Tozer House

Detailed findings

Background to this inspection

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

This inspection took place on 8 March 2017 and was unannounced.

One inspector, an inspection manager and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in caring for young adults.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed two previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care in the communal areas of the home during the afternoon and early evening. We looked at care records for six people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at three staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with seven people using the service, two relatives, the registered manager, two senior support workers, three support workers and the chef.

Good

Is the service safe?

Our findings

At our last inspection, in January 2016, we found the provider had not ensured safe management of medicines or that there were sufficient quantities of prescribed medicines. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We set a requirement and asked the provider to take action. At this inspection action had been taken to improve how medicines were managed and to ensure regular audits took place. The requirement was met.

Since our last inspection, new medicines cabinets had been installed in each person's bedroom. Their Medication Administration Record (MAR) were also stored individually in their rooms. People told us this change had been discussed with them. Most people appeared very happy with this arrangement. One person said, "They made a mistake years ago, mixed up my tablets with someone else's and we were both unwell. Now they have to come in to me, it's more private, I like it". The registered manager explained that medicines were administered by senior support workers or by her. Each staff member responsible for administering medicines had attended training and their competency had been assessed. At the end of each shift, the senior coming on duty checked the MAR for errors, gaps in recording or omissions in administration. One senior support worker told us, "We do check what the last person did on their shift. The systems are working well now". There was also a new system to manage medicines when they were transferred outside the home, such as when a person went to stay with relatives or friends.

Each person's care plan contained guidance on how they preferred to receive their medicines and on when and how any 'as needed' (PRN) medicines should be given. This information was specific to the person and up-to-date. Support workers had attended basic medicines training to enable them to safely assist people with applying topical creams. Topical creams include moisturising and barrier creams and are used as part of people's personal care. We reviewed the storage, administration, recording and disposal of medicines and found the systems in place to be safe and working efficiently.

Before a person moved to the home, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in mobility, medication, safely accessing the community or from behaviour that might challenge, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support people required from staff. We reviewed the behaviour management plans for one person. These contained detailed information for staff as to the person's behaviour, what might trigger certain behaviours, who could be at risk and strategies for prevention, recovery and crisis management. Staff at the home also worked closely with staff from the day centre the person attended so that information was shared and consistent approaches used. In a recent review, we saw that allowing the person space in a calm area was working well. At the home, staff had identified a quiet space for the person to use when needed.

The registered manager was in the process of updating the risk assessments in place. The new format combined all risks into one assessment for the individual that was tailored to their needs. Staff told us that this should make it easier for them to quickly understand risks in people's care and the support they needed. We noted two instances where a risk had been identified in the care plan but the risk assessment

was missing. For example, the care plan for one person living with diabetes contained guidance about podiatry care, nutrition and blood sugar checks but there was no risk assessment in place. We shared this feedback with the registered manager who ensured the necessary assessments were added to the care plans.

Where accidents or incidents occurred, these were logged and reviewed. This helped to identify any patterns or trends and to reduce the risk of future injury. Staff had taken action to minimise risks to people. This included seeking input from healthcare professionals where needed, for example seeking advice from the district nurse for pressure areas. In other cases, staff had changed a person's compression stockings for another brand, felt to be less slippery. They also encouraged the person to wear their slippers if they got out of bed at night so as to reduce their risk of falling. Each incident had been reviewed by the registered manager or a senior support worker to ensure that appropriate action was taken. We noted that where staff used body maps to record the position of injuries, there was not always evidence that these had been reviewed or signed off. The registered manager advised that they would incorporate this into their audit of accidents and incidents.

At our last inspection, in January 2016, we found that, although the registered manager had notified the safeguarding team of incidents that occurred, they had failed to notify the Commission of four allegations of abuse. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We set a requirement and asked the provider to take action. In the months since our last inspection, we received notifications from the registered manager. At this inspection action we discussed the various notifications that services are required to send to the Commission with the new registered manager who demonstrated an understanding of her responsibilities. The requirement was met.

People felt safe living at Tozer House. One person told us, "It's a very safe place. I'd go to any of the staff about anything wrong, they'd sort it out". Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Staff had been proactive at seeking appropriate support for people, for example when there was a concern over how their personal finances were being managed. When another person had unexplained bruising, staff had liaised with the person, their representatives and professionals and had installed a camera for a short period of time. This demonstrated that the bruising had been caused by erratic movements and alleviated any other cause for concern. Staff told us they felt able to approach the registered manager if they had concerns. Information about safeguarding and how to raise a concern was displayed on notice boards in the home.

There were enough staff on duty to keep people safe. The staffing levels varied throughout the week, depending on how many people were home and on the allocation of one to one hours. The general pattern was that a senior support worker was on duty around the clock, with three support workers in the early morning and from 3.30pm when people returned home from day centres. In the middle of the day there was usually one support worker on duty during the week and two at weekends. At night the senior was on the premises on a sleeping shift with one support worker covering the home. The staffing levels could be adjusted to respond to changes in people's needs. The senior support worker responsible for the rotas told us, "Needs have changed so we've tried to reflect that on the rotas". They added, "The regular team of contracted staff has added to the continuity for customers". Staff were happy with the staffing level and felt confident they could meet people's needs safely. One support worker said, "Staffing is enough, there are three on every evening to 9pm, so there is always one person in each house and the third person floats between them, according to where the greatest need is". Another staff member told us, "There's an even flow at the moment".

Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

Where necessary, the service used agency staff to maintain staffing numbers. Staff told us there was good continuity in the agency staff who worked at the home. One senior support worker said, "We get the same people again and again". The registered manager said they had been able to reduce agency use as vacancies had been filled, but that it would still be necessary to cover sickness and annual leave. Before agency staff worked in the home, their skills and experience had been checked. They had also received an induction before starting their shift.

Good

Is the service effective?

Our findings

Staff received training to enable them to provide effective care and support to people. Training made mandatory by the provider included safeguarding, medication, moving and handling, first aid, fire, positive behaviour and epilepsy awareness. There were also opportunities for staff to undertake additional training. This included Makaton, dementia care and diplomas in health and social care. One senior support worker said, "There is a vast amount of training". Another told us, that training was available, "Depending on the needs of the people we are working with". Staff felt confident in their skills and abilities and told us they received a high level of support from the registered manager. One senior support worker said, "(Registered manager) has been very supportive of the training". A support worker confirmed this saying, "(Registered manager) has been very vigilant with that (training)". The registered manager had a system to monitor the progress of staff training and to ensure that refresher courses were booked and completed as required.

New staff completed a period of induction, which included training and shadowing of experienced staff. This helped them to understand their role, to get to know people and their support preferences. During their first 12 weeks of employment, all new recruits who had not previously worked in care were expected to complete the Care Certificate, which is a nationally recognised qualification. At the time of our visit, no new staff had completed the Care Certificate as they all had prior experience of working in the sector.

Staff felt supported. There was a system of supervision which gave staff the opportunity to discuss their role and aspirations. One support worker told us that they supervision included a discussion on their role, keyworking responsibilities (this is where a staff member takes particular responsibility for certain people and their care), care plans and personal development. One support worker said, "I do find supervision useful. You can sit down with your manager and reflect on your practice". Another explained how they had requested additional training in positive behaviour and that this had been booked. The registered manager aimed to hold staff supervision every two months. She told us, however, "The door is open, staff don't need to wait". At the time of our inspection, the registered manager was relatively new in post and staff had not attended their annual appraisals. The registered manager explained that they were changing the format of the appraisal and that these meetings would then be scheduled.

A number of the people living at Tozer House used methods of non-verbal communication. Some staff had an understanding of Makaton and used symbols to improve their communication with specific individuals. The registered manager showed us a page of symbols that were understood by one person. These included, 'bus', 'work', 'shops', 'walk', 'football' and 'bed'. Another person used a system known as 'objects of reference'. This had been recommended by the Speech and Language Therapist who felt the person understood objects directly linked with their activities better than symbols or photos. We observed staff using this system, such as by showing the person their hairbrush to ask whether they wished to be assisted to do their hair before going out. We observed staff working with a third person. The support worker used key words to communicate, rather than speaking in full sentences. Throughout the home we noted pictorial and easy to read guidance for people, including signage on doors such as for the toilet and instructions for the action to take in the event of a fire. We observed that staff were skilful in communicating with people according to their communication support needs and preferences.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, staff had made applications on behalf of three people who were considered to be deprived of their liberty. These applications were awaiting assessment by the local authority team. The registered manger explained that a further six applications were required for people who had recently moved to the service. We received confirmation following our inspection that all necessary applications had been submitted.

Staff understood the requirements of the MCA and put this into practice. One support worker said, "We will assume they have capacity". People had been asked to consent to decisions relating to their treatment. Staff had completed capacity assessments relating to people's ability to be involved in a variety of decisions. For one person we read, '(Name of person) has the mental capacity to make decisions around day to day issues' and, '(Name of person) does need a degree of help to make an informed decision around significant life choices'. Staff were able to describe how they would assist people with decision making and the action they would take if the person was unable to make the decision at the time it needed to be made. One support worker told us, "I would involve community team for assessment". A senior support worker said, "If there is a question about capacity of different aspects of care and life skills we liaise through the community teams. We sometimes need to make best interests decisions about medicines". We observed staff involving people in day to day decisions, offering assistance and waiting for people to respond to questions. Records demonstrated that where people had refused support on occasions this had been respected. For example, in the daily notes we read, 'Refused a shower' and, 'Refused to go to bed when offered'.

People told us they enjoyed the meals at the service. One person said, "We've got a good cook here, does a lovely roast but everything is really nice. Staff do breakfast for us in the house. It's a nice dining room in our house but I like to go to the meal with everyone else at tea time". A relative told us, "The meals appear very good and visitors can eat here. It's cooked fresh. They have good access to drinks and biscuits in the houses". People who attended day centres tended to make and take a packed lunch with them. The main meal was served in the evening. There was a choice of hot dish available at the point of service, along with regular alternatives such as sausages, fish cakes, jacket potato or omelette which could be made to order. The chef told us, "If it's not on the menu but the provisions are here, I'll do it". We observed the evening meal. Staff ate at tables with people, which made for a pleasant social occasion and discrete staff observation and support as needed. Some people preferred to take their meals back to their houses and were free to do so.

The chef had information about people's dietary needs, allergies, likes and dislikes. Meals for some were served 'soft' to aid with swallowing. For one person who was diabetic, the chef purchased diabetic ice cream. This person told us, "I have to watch what I eat, I'm diabetic. They are all kind to me, they understand I have to be careful of my diet". Staff monitored people's food and fluid intake to ensure they were receiving sufficient to eat and drink. A senior support worker explained to us how one person was now offered a more substantial snack later in the evening. This was because they had started to eat less at dinner time. They told us that the person's pattern of eating and drinking had altered. The registered manager advised that this person had been seen by their GP and that a medicines review had also taken place.

People had access to healthcare professionals and the service worked in collaboration to ensure their needs were met. Staff monitored people and picked up on changes in their health. Records confirmed that people had been supported to meet with a variety of healthcare professionals including the GP, hygienist and chiropodist. One person told us, "I'm seeing the chiropodist tomorrow, it's been arranged because I've got a problem and it hurts to walk. They always get a doctor or whoever you need quickly. I needed the paramedics once, the staff knew what to do". A relative said, "(Name of person) needs encouragement to chew and there's a related need for mouth and dental care, which have both been excellent. The GP is contacted as necessary". Each person had a Health Action Plan (HAP) in place, which had been reviewed with the GP. A HAP details information about the person's health needs and the professionals involved.

Good

Is the service caring?

Our findings

People spoke highly of the staff and said they enjoyed living at Tozer House. Many of the people enjoyed friendships with others who lived at the home. One person said, "My friend comes over (that is from Rosemead to Bramley), we are great friends, we spend a lot of time together and have meals together. I ring (relative) every day on my mobile. I get on with all the staff, this is a very friendly place". A relative had written a note of thanks to the home. We read, 'Thank you on (name of person's) behalf for the wonderful care and support you have given her over the many years while she was living at Tozer. You have looked after her beautifully and I am very grateful to you all. You are special people'.

Each person had a keyworker assigned to take responsibility for their well-being, care and support. People had been involved in choosing the staff member they wished to support them in this way. Staff had also been consulted on who they felt they would be best placed to support. We noted examples from the care plans of the support keyworkers provided to people. We read, 'My keyworker also supports me to achieve leisure and social activities', 'My keyworker supports me to book and attend my appointments' and, 'My keyworker supports me to go to see my girlfriend'. One person showed us a memory box they had started with their keyworker. This work was related to bereavement and the keyworker had involved an external psychologist. They were also working to set up a family visit. A relative told us, "The keyworker relationship is very strong. (Name of person) has learnt a lot from (their keyworker). On Wednesdays they start with domestic chores then go out. (Keyworker) has tried lots of things, took him to an art exhibition because we couldn't". People were able to tell us who their keyworker was and about the things they did together. The system appeared to be working very well and provided people with continuity and a familiar person to go to for support or advice.

People were involved in planning their care and support. Care plans contained information about people's preferences, wishes and aspirations. People discussed their care and support with their keyworkers and were encouraged to express their views. One senior support worker told us, "We sat down together and went through all aspects of his care". They added that they were trying to make the care plans more accessible by use of photos and pictures. Each year, a review of the person's care was held. This is where the person met with staff, external professionals and family members to discuss what had gone well and what they wished to achieve in the coming months. For one person, this was to go independently on a bus into town. Staff explained how they were working towards this goal, firstly by working with the person on road-safety awareness.

People felt involved and were able to make choices about their daily routine and activities. One person told us, "I've agreed how I like my life organised. I have a taxi now, as I can't get in the minibus. I don't go to day centre on Thursdays; I have a quiet day and catch up on my washing. It suits me here. I've got a TV in my room, I watch my own TV after tea, that's how I like it. I can choose what I want to join in with". There were regular meetings for people who lived at the home. People told us they were free to speak up and were informed about what was happening, such as how and when new flooring was going to be laid. One person said, "They like to keep it up to date. We have our own house meeting and get asked if we like our rooms, and what kinds of things we'd like to do. We are well informed about things that happen. If someone leaves,

we are told why, which makes it feel better".

We observed that the houses and people's bedrooms were individualised. There were pictures and ornaments, in one case revealing a love of dogs. One person told us how much they liked their room and were happy to be able to display the paintings they had done at the day centre. Staff supported people to maintain relationships with people who were important to them. When we visited, one person was going out to post greetings cards to family members, another told us they were planning to go out with staff in the coming days to buy a present for a relative.

People were supported to be as independent as they were able. Care plans described the support people needed from staff and detailed those tasks and pursuits people could manage independently. For example we read, 'I need prompting and some assistance to shave and clean my teeth', 'Please support me to wash my hair; if you hand me the shampoo and give it to me I can be quite independent' and, 'Please help me to be independent by supervising to make packed lunch for work the next day'. In the daily notes we read about the support people had received. For one we read, 'Self-creamed and did own dentures'. A support worker told us, "We support them in what they can do and adjust to changing needs. It is giving someone the self-confidence that they can do it". We observed this support worker assisting a person to change the television channel. They offered guidance but allowed the person time to do it by themselves. A second person asked for their hands to be cleaned after eating a chocolate biscuit. The support worker helped the person to do this but did not do it for them.

Each care plan had a section entitled 'Independent living skills' and most people had one to one time allocated to pursue these skills weekly. This included shopping, cleaning, laundry and management of finances. The registered manager explained how they hoped some people would be able to move on from Tozer House into supported living rather than staying in residential care. One person told us, "They are trying to help me maintain independence for when I move on. I do a bit of baking, they help me clean and tidy my room. I get breakfast when I want it from the kitchen downstairs".

People were treated with dignity and staff showed great respect for them. We observed that staff called people by their preferred names and always engaged with them before providing any care. When people were in their bedrooms, staff knocked and waited for a response before entering. Staff told us that they would offer to go with a person to their bedroom to discuss anything that was upsetting them in privacy.

Good

Is the service responsive?

Our findings

People received personalised care and support from staff who knew them well and understood their needs. People were supported with their individual interests and hobbies. A relative told us how staff engaged with their son around their in their love of football. A support worker described how one person wanted to develop their reading ability and how they were supporting them in that. They added, "Some of the younger men here have a real interest in modern ways of communicating, as they should at their age, and it's positive that they are encouraged to embrace that". One person was very excited to show us a laminated communication photo sheet with pictures of significant family members & friends. On the reverse was list of birthdays and other significant family dates. For another person, a support worker had made a chair for their pet soft toy so that it did not keep falling off their walking frame.

Staff were in the process of revising people's care plans. The registered manger had introduced a new format. At the time of our inspection, staff were updating the care plans and archiving out-dated information, ready for the transfer. The new format had a clear index and included coloured photos and images to aid people's understanding. From the one new care plan that we reviewed, it was clear that the person had been directly involved. A support worker told us, "We want to make the residents more part of the support planning. It's all done sitting with the person". There were sections on the person's medical diagnosis, their family, their usual weekly timetable, support needs with personal care, communication and independent living skills (such as shopping, money, socialising, transport and household chores). The information was presented under the heading, 'What I can do'. For example we read, 'I can get a taxi on my own but I need taxis booked for me'. Staff were positive about the changes and told us they had been involved in devising the new format.

The existing care plans contained detailed guidance for staff on people's needs and how they wished to be supported. In the section about one person's communication needs we read that they struggled to understand timeframes and how long they may need to wait. We read, 'It is better to explain timeframes using events or activities, for example 'After breakfast' or 'before tea' as opposed to 'in half an hour' or 'at 5pm''.The information was presented in a variety of styles, making it more difficult to find the relevant guidance. In a small number of instances, we found information to be missing. This was quickly addressed by the registered manager who sent us copies of the revised documents following the inspection. The registered manager aimed to have all the new care plans completed by the July 2017.

Monitoring records were in place to ensure that care had been delivered in accordance with the care plan. This included records of when people had been supported with personal care, topical creams and oral hygiene. Staff also monitored people's weight, usually on a monthly basis. Each person had attended a health action plan meeting with their GP to review their health needs and the input from external professionals. There were also a number of medicines reviews taking place. These had been requested by the registered manager to ensure that people were on the correct medicines. As a result an antidepressant for one person had been stopped and staff had been asked to be vigilant to any signs of anxiety or depression. Staff attended daily handover meetings where they discussed how people were and any changes in their health, daily routine or needs. Staff told us that these meeting were useful and that they

were reminded of significant appointments or time-specific actions.

Throughout our visit, people appeared to be busy and engaged in various tasks and pursuits. There was information in each person's care plans about how they enjoyed spending their time and any particular leisure interests. During the day, most people attended day centres, returning mid-afternoon. The registered manager explained how they were developing the range of activities on offer to people, so that they had more options available to them in the evenings and at weekends. One relative told us, "We wanted to see more staff for social support and (registered manager) has been working on it. It is improving now, for example they have Tuesday evenings out". There was also table tennis, a weekly disco where people met with other friends locally and one support worker who was trialling an arts and crafts session on a Thursday evening. On occasions, visiting entertainers were booked and people asked for their feedback before making further bookings. Staff maintained a record of how people had spent their time. For one person this included the day centre, bowling, watching a film, one to one and household tasks.

People felt confident to raise any concerns with staff. One person said that if anything were wrong, "I'd speak to staff, they'd put it right for me". Information was displayed in the houses in an easy to read format, describing how to make a complaint. People had also been asked during house meetings if they had any issues they wished to raise. Staff explained how issues raised by people were quickly addressed. For example, one person was frustrated that they did not know in advance which staff member would be providing their one to one support. The person had agreed to come and ask the registered manager two weeks in advance. Staff also tried to ensure the same staff member was allocated for these hours to provide continuity. The registered manager had received one complaint since January 2016. This had been responded to appropriately, in line with the provider's policy and to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

At our last inspection, in January 2016, we found the provider did not have systems and processes in place to assess, monitor and improve the quality and safety of the services provided. Furthermore, records in respect of staff and the management of the service were not always up-to-date and could not always ben easily located. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We set a requirement and asked the provider to take action. At this inspection action had been taken to improve how the service was running, to identify and see through necessary improvements. The requirement was met.

Since our last inspection, a new registered manager was in post. They started in post during October 2016 and registered with us in December 2016. Staff spoke positively about the change at the service since the registered manager's appointment. One support worker said, "(Registered manager) has made a big difference as manager. We already had a good base of quality care and she recognised that, has brought existing staff along with her in establishing her value base and getting changes moving. We've made steady progress since the last inspection". Another support worker told us, "Since (registered manager) came, it's quite organised and flowing. It's gone seamlessly really". A relative described the registered manager as, "Approachable and capable".

The registered manager had taken time to understand the service and to meet with all of the staff, both on the day and night shifts. She told us that she was working to build the team. She said, "We have a plan on how we are going to do things and how we're going to get there together". In each of the houses we noticed a pictorial profile about the registered manager, which had been used to help people get to know her and her role. The registered manager told us, "I try to lead by example, to break down the barrier between staff and seniors". The registered manager was included in the rota so staff knew when she was available and could be called upon to support people if needed.

The registered manager was supported by a team of senior support workers. Many of the seniors had delegated responsibilities, such as for the rotas, medicines or training. One senior told us, "We've seen great improvement in how the service is led. Things are being properly delegated. Teamwork has improved". There were regular staff meetings, for seniors and for all staff. Staff felt they were listened to and were part of the development of the service. They told us that items raised during meetings were addressed. One support worker told us, "It's brilliant, we can see some massive changes. It's reassuring".

The former and current registered managers had worked actively with the provider to ensure that improvements were made to the service. The action plan submitted to the Commission following the last inspection had been reviewed by the provider in August, September and December 2016. There had also been other audits by the provider including of medicines, care plans, supervision, training and safeguarding. The service had been audited by external agencies including the fire and rescue service and the pharmacy. In-house audits had been carried out of infection control, health and safety and medicine management. Following each audit action plans were put in place and updated to show what had been completed and to allocate resources and timescales to the outstanding work. The registered manager had created a log

entitled 'continuous improvement' where she recorded ideas on how to further develop the service. We found that the quality processes in place had delivered improvements and ensured compliance with the regulations.

The registered manager maintained accurate records in relation to staff training and supervision. Staff told us the registered manager had been proactive at ensuring they attended necessary training and in supporting them to pursue additional courses. Staff training was up-to-date and refresher courses had been booked where necessary.

The registered manager had asked people for their feedback about the service. Twelve surveys had been returned, some completed with the help of staff. The surveys were presented in a pictorial format. They asked people whether they felt in control of planning their care and support, if they were able to choose what they wanted to do, if they thought staff were good at their jobs, if they were happy with the support and for any ideas on what could make the service better. The registered manager had not yet completed their analysis of the results but the initial findings were positive. The registered manager explained how they intended to use surveys of people, relatives and staff to seek feedback and make improvements.

There was a happy and open atmosphere at the service. A notice board displayed staff photos alongside their name and roles. A newsletter had been started to share with relatives and to keep them updated with developments and happenings at the service. People, relatives and staff felt confident to make suggestions and to raise any concerns. One relative told us, "There have never been any communication problems with any of the staff here. If they've had a problem with (name of person), they've shared it. It's good, all is open and honest".