Atlas Healthcare Limited

Huntercombe House - Peterlee

Inspection report

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

Overall summary

This inspection took place on 25 and 26 November 2015 and was unannounced. This meant the registered provider and the registered manager did not know we were carrying out an inspection.

Huntercombe House in Peterlee is registered to provide accommodation for up to 21 adults with learning difficulties. The home is on two floors. Accommodation is provided for people either in individual bedrooms on the first floor or in bedsit type accommodation known to people as 'flats' on the ground floor. Each person's accommodation has ensuite facilities. There are communal sitting rooms on both floors and a communal dining room on the ground floor.

Summary of findings

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. Following our last inspection the acting manager had been appointed as the manager and had registered with the Care Quality Commission.

We found people were protected from abuse because staff knew what to do if they had any concerns.

The registered provider had a robust recruitment and selection procedure in place and carried out all relevant checks when they employed staff.

Checks were regularly carried out on the building to ensure people were safe. These checks included fire safety, water temperatures, extractor fans and window restrictors.

We observed two lunchtime sessions in the dining room and found the atmosphere was calm and conducive to eating well. Staff ate their meals with the people living in the home and chatted to people.

We observed staff supporting people in the home and found they were skilled in working with people and could distract people from adverse behaviours as well as anticipating their needs.

We found staff were supported by a multi-disciplinary team (MDT), Staff were able to learn about people's conditions and how they could support them from the MDT who also arranged to bring in experts to support staff.

The registered provider had adapted the home environment to meet people's individual needs. This included changing the use of a bedroom into a quiet space and adapting a bedroom into a sensory room to meet one person's needs who felt more comfortable in an environment designed just for them.

We found staff in the home valued and respected people.

We found people received care and support from staff who knew and understood their history, likes, preferences, needs, hopes and goals.

The registered provider had in place a training kitchen to support people to gain skills to support their independence. We observed people cooking in the kitchen and they were enjoying the activity.

We found the service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and friendships.

People were supported and encouraged to engage in activities in the home and in the local community. Since our last inspection we saw activity levels had increased.

Each person was supported using a personalised intervention plan formulated at a multi-disciplinary team (MDT) meeting. Three or four people were reviewed each week and people were invited to attend their section of the meeting. The intervention plans were reviewed and updated at MDT meetings where issues or concerns about people were examined; plans were put in place to be carried out by named responsible persons with outcome measures identified.

We observed an easy rapport between staff and the registered manager, and service users and the registered manager.

Following research into ensuring people were cared for by smaller groups of staff the registered manager had arranged the service into pods. A pod consisted of three or four people who lived in the home with a group of approximately 11 staff around them. This prevented people being cared for by a large staff group and meant that staff needed to know about a small group of people in depth.

The service supported by the occupational therapist had developed an approach to promoting people's well-being by providing a framework for staff and increasing people's activity rates. The approach had been documented and recognised by the College of Occupational Therapists and was shared with other local service providers.

The service was the regional winner of the Great North East Care Awards, for their work in supporting a person with challenging behaviours and went on to be a finalist in the Great British Care Awards 2015. This meant the registered manager and the staff had received national recognition for their work.

Summary of findings

The registered manager had led developmental sessions for the staff to look at their own values in the service and the service had created its own set of values building on those of the provider.

The registered provider had in place a quality audit system which measured the service. The registered manager was knowledgeable about the reasons behind what the service had scored and told us what they were doing to continuously improve the service.

The registered manager explained that in order to support staff, encourage joint and more effective working they had developed a number of keyworker roles around each person's needs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe

Good

We found people were protected from abuse because staff knew what to do if they had any concerns.

The registered provider had a robust recruitment and selection procedure in place and carried out all relevant checks when they employed staff.

We saw risks to people were discussed in the Multi-Disciplinary Team (MDT) meetings where care planning balanced risks to the person with their needs to develop their skills and try new activities.

Is the service effective?
The service was effective

Good

We observed two lunchtime sessions in the dining room and found the atmosphere was calm and conducive to eating well.

We observed staff supporting people in the home and found they were skilled in working with people and could distract people from adverse behaviours as well as anticipating their needs.

The service adhered to the requirements of the Mental Capacity Act 2005 and had made the required applications to supervisory bodies to deprive people of their liberty in order to keep them safe.

Is the service caring?
The service was caring

Good

People told us the staff were kind to them and told us they liked spending time with staff.

We found staff in the home valued and respected people.

We found people received care and support from staff who knew and understood their history, likes, preferences, needs, hopes and goals.

Is the service responsive?
The service was responsive

Good

We found the service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and friendships.

Active support was the approach being used in the home to encourage and support people's engagement in activities. Since our last inspection we saw activity levels had increased.

Summary of findings

Each person was supported using a personalised intervention plan formulated at the MDT meeting. The intervention plans were reviewed and updated at MDT meetings where issues or concerns were examined; plans were put in place to be carried out by named responsible persons with outcome measures identified.

Is the service well-led?

Good

The service was well led

The registered manager had arranged the service into pods to improve the continuity of care people received. A pod consisted of three or four people who lived in the home with a group of approximately 11 staff around them. This prevented people being cared for by a large staff group and meant that staff needed to know about a small group of people in depth.

The service had researched and implemented an approach to promoting people's well-being by increasing their activity rates. Their implementation of this approach recognised and published by the College of Occupational Therapists and was shared with other local service providers.

The service was the regional winner of the Great North East Care Awards, for their work in supporting a person with challenging behaviours and went on to be a finalist in the Great British Care Awards 2015. This meant the registered manager and the staff had received national recognition for their work.

Huntercombe House - Peterlee

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 November 2015 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist advisor whose background was in nursing and occupational therapy and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this inspection the expert by experience had a background in caring for a person with learning disabilities.

Before we visited the home we checked the information we held about this location and the registered provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised since the last inspection, which took place in August 2014.

During our inspection we spoke with eight people who used the service and carried out observations of people who were unable to verbally communicate with us. We carried out observations of people using the service. We spoke with 12 staff including the registered manager, members of the multi-disciplinary team, senior care staff, care staff, catering and maintenance staff. We also spoke with a visitor to the home and two external professionals.

Good

Is the service safe?

Our findings

We spoke with people about their experience of being safe in Huntercombe House. One person said, “Been here a couple of years – it’s not that bad – aye I feel safe – my stuff stays in my room its safe there.” Another person said, “Aye its safe enough – I have a key to my room so my stuff is safe enough in there”. Another person said, “I like it and I feel safe. I have keys to my flat and I have a safe in my room where I keep my bank cards and wallet and things. My meds are kept in the meds room to keep them safe.”

We saw a copy of the registered provider’s safeguarding policy. One staff member told us they had received, “Lots of training about how to spot different types of abuse”, they told us they knew how and who to report it too and said they would be prepared to whistle blow if necessary. Other staff agreed with this perspective. Staff had access to information on the notice board about the registered provider’s whistle blowing policy. We found people were protected from abuse because staff knew what to do if they had any concerns.

The registered provider had in place a staff disciplinary policy and the registered manager gave an account to us of its recent use in relation to poor safeguarding practice. The registered manager had sent the appropriate notification to CQC regarding the issue.

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been explored. The registered manager had introduced case scenarios for prospective staff to respond to. They explained to us this was to check if people had in place the appropriate values to work with the people who lived in the home. This meant that the registered provider had a robust recruitment and selection procedure in place and carried out all relevant checks when they employed staff.

We asked people if there were sufficient staff on duty to care for people. One person said there were, “Plenty of staff to chill out with - and they take me to concerts”. Another person said, “Sometimes I have to wait to do things – you have to plan but its ok I can usually manage to do as much as I like”. A staff member said, ”Sometimes there’s enough staff sometimes not – especially if there is sickness in the staff – planned leave is usually ok but sickness we just have to make do”. We looked at the rotas and found there were enough staff on the rota to care for people. The registered manager told us that it was unplanned staff sickness which caused the biggest problems. We found the registered provider had in place bank staff they used to cover any staff shortages.

At our last inspection we found the home had not reduced the risks associated with the spread of infections. During this inspection we saw there were effective systems in place to reduce these risks. We found all areas including the laundry, kitchen, lounges, bedrooms and en-suites were clean, pleasant and odour-free. The local Infection and Prevention Control team had visited the home and made suggestions to improve the home’s hygiene. This work had been carried out. Work had also been carried out in the laundry to ensure a laundry flow from a dirty to a clean area. This meant the registered provider had acted on the breach of regulation and was now complying with the regulation.

We found there were regular maintenance checks in place to ensure the building was safe including fire safety records, water temperatures, extractor fans, window restrictors. Regular fire drills were held. On checking the records we found some of the emergency lighting had not been working for some months. A member of staff explained to us efforts had been made to try to repair the lights without success. During our inspection we asked the registered manager to urgently address the issue and they put plans in place for the system to be repaired. Following the repairs the registered manager confirmed to us the emergency lighting was working.

Accident records were kept by the registered manager. We saw there were few accidents and actions were taken to avoid a reoccurrence. There was evidence in the home of risk assessments and risk management plans. We found people had individual risk assessments in place. We saw risks to people were discussed in the Multi-Disciplinary Team (MDT) meetings where discussion took place to

Good

Is the service safe?

balance risks to the person with their needs to develop their skills and try new activities. For example one person's kettle was removed from their room at night as there were concerns the person would scald themselves. The person was allowed to keep the kettle in their room during the day and use it with staff supervision. The MDT meetings involved professionals internal to the service who told us that they can invite external professionals to attend. External professionals confirmed they attended. Family members and people who used the service were also welcome to attend.

One person told us, "They bring me my meds and I take them. They are always on time – better than the last place". We looked at the administration of people's medicines and found there were arrangements in place to ensure the safe storage and disposal of people's medicines. We saw the medicines fridge daily temperature record and saw that all temperatures recorded were within the 2-8 degrees guidelines. A controlled drug has potential to be open to abuse. We saw controlled drugs were appropriately stored in a locked cabinet. We checked the expected amount of the controlled drugs stored on the premises with the actual amount and found the records matched what was stored.

The registered provider had in place Medication Administration Records (MAR). These MAR charts were up-to-date and contained no gaps. We asked about the arrangements in place for people who needed to take their medicines when they visited their relative's home. Staff showed us how this worked and people's medicines were checked when they left and when they returned. Weekly medicine audits were in place to check if good medicine practices were carried out. This meant people were given their medicines safely.

We found people's human rights were protected. For example a member of staff explained the measures that were taken in order to ensure that people were able to stay in contact with their families, visiting them when possible, even when they lived some distance away. The registered manager had introduced a keyworker role to the staff group entitled 'Family Liaison.' The defined tasks for this role were to provide links with family members so that people in the home could sustain family relationships. Staff told us who had the family liaison role and what they were expected to do. This meant the home was promoting people's rights under Article 8 of the Human Rights Act 1998: the right to respect for private and family life.

Good

Is the service effective?

Our findings

We spoke with people about eating and drinking at Huntercombe House. One person said, "Sometimes I eat in the dining room, sometimes my flat. I like cooking my dinner but not my tea. Jacket potato today." Another person said, "Its good food, there's lots of things I like". We observed this person go into the dining room; they chose and collected the ingredients. A staff member gave the person the choice of cooking in their flat or the upstairs kitchen. Another person told us, "Foods alright – a menu comes round and we choose. We can make drinks whenever we want". One person said. "Don't like the food much – it's the same things every week – meat's a bit chewy. I can make cups of tea whenever I want – I do it but staff put water in in case I burn myself". Another person said, "Sometimes cook in my kitchen – I like to make omelettes its nice food here – the chef makes good lasagne and his stir fry with black bean sauce is gorgeous". This meant people were engaged in nutrition in the home, had choices and were supported in their choices.

We found kitchen staff were informed of people's food preferences; these records were kept in the kitchen and accessible to the catering staff. Staff showed us their work in progress to introduce pictorial menus for people living in the home. They showed us photographs of the meals they had prepared to people could see the food and choose what they wanted to eat. The staff told us they had recently been trained on the special needs of people with Prader-Willi syndrome, and how they had been able to meet relatives of a person with this condition to understand its impact. People with Prader-Willi syndrome show an increased appetite which can lead to excessive eating and life-threatening obesity. This meant kitchen staff were participants in people's care and were working as a part of a care team to meet people's needs.

We observed two lunchtimes in the dining room and found the atmosphere was calm and conducive to eating well. People chose where they sat and staff sat with people and ate their own food. The food served from the kitchen looked appetising and included vegetables with a choice of main course. People followed a set pattern of going to the hatch, choosing their food and later returning their dirty plates and cutlery on a trolley. Staff chatted with people and helped where necessary but promoted independence. For example they offered to help cut up the food. We observed staff chatting to people One person started to sing in the dining room and staff joined in and gave the person praise. We later read in the person's care file this demonstrated the person was happy and staff had followed the guidance to support them. Another person in the dining room chose their meal but decided they did not like it. We observed staff without question calmly remove their plate and ask the person what they would like as an alternative. We found staff supported people to eat and promoted their choices.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered provider had carried out assessments of people's needs and had appropriately made applications to supervisory bodies to deprive people of their liberty. In people's care files we found capacity assessments had been carried out and more specific guidance had been given to staff on how to involve people in decision making. In one person's file we read, 'I can understand information if it is explained to me by someone I know and trust'. We found the home had not only considered a person's capacity to understand information but also the relationship element in who conveyed the information to the person which enabled them to make an informed decision. Staff were aware of DoLS and the levels of supervision required by each person both in the home and out in the community to help protect them.

We observed staff supporting people in the home and found they were skilled in working with people and could distract people from adverse behaviours as well as anticipating their needs. For example one person was distracted by staff from repeatedly touching switches. The

staff suggested other activities which the person might have liked to do. This distracted the person and the staff member and the person walked down the corridor to carry out an activity. Another person was supported to move to a different area of the home where the environment could distract them from pacing the corridors. We saw a member of staff sensitively persuade a person to discuss healthier food when they felt their weight had been criticised by a relative. This meant staff were aware of people's needs and could intervene to prevent any adverse behaviour from escalating.

The registered provider had a policy in place for use of physical interventions. We spoke to staff about the use of restraint in the home as defined in the registered provider's policy as an approach to manage aggressive and violent behaviour. One staff member said they had received training in restraint but had "Never had to use restraint so far." During our inspection we found staff supported people to do as they wished. We did not observe any staff behaviours which could be construed as restraint.

One person told us, "I don't like a lot of noise – the house can be too noisy so I go and sit in the quiet lounge – if someone's kicking off and it's really bad they can shut the doors off so I don't get frightened and I feel safe". We found the provider had adapted a bedroom into a small quiet lounge for people wishing to have a quiet space. Further adaptations had been made to another bedroom to allow a person their own sensory room close to their bedroom where they could go and not be interrupted by others. This room had a ball pool and there were different textured materials on the wall to meet the person's sensory needs. A member of staff explained to us how the garden was organised. We looked in the garden and found it had been adapted to provide an appropriate environment which included a range of different spaces using different textures and garden ornaments as well as different plants. The staff member explained to us there were improvements still to be made to the garden to improve people's sensory experiences of their outdoor environment. These were spaced out so people could move between them. This meant people's individual needs had been considered and the provider had tried to meet the needs throughout the premises and in the garden.

The provider had put in place information booklets for new staff including induction checklists and an overview of the Care Certificate. This meant staff were given information about their learning requirements. Staff confirmed to us they had received an induction period and had learned through training and shadowing other more experienced staff before being allowed to supervise people in the home. The registered manager had also looked at the learning programme for staff and devised a list of what learning each staff group should undertake to ensure they were competent to carry out their role. We found the home was in a transition period as a new e-learning programme was being prepared for staff. The registered manager showed us the programme and responded to staff questions about when they would be getting their log on details and what hardware they could use to access the e-learning.

A MDT met each week to discuss the needs and progress of people living in the service. Summaries of the MDT meeting notes were held within each person's care plan and we saw planned actions were subsequently carried out. Members of the MDT described to us how referrals could be made to clinicians based outside of the unit, and they received prompt responses from GPs, the Health Facilitation Team, or Speech and Language Therapy Team (SALT). One person told us staff always get them an appointment with their GP if they want one.

We looked at staff supervision and found not all staff had received regular supervision from their line manager. A supervision meeting occurs between a staff member and their line manager to discuss their progress, their concerns and any training needs. However whilst the pattern of supervision meetings with line managers was not regular we found the Clinical Psychologist provided clinical supervision either as a part of a team caring for one person or as an open clinical supervision session for any staff member. This meant staff received support and supervision not only pertinent to their role but also pertinent to the people who lived in the home.

Members of the MDT told us they had required time for them to become embedded in the service and have credibility with the staff. We found they offered additional supervisory support to staff on a one to one basis or as a group to address specific staff learning needs around people's conditions. For example a session had been arranged on Bi-polar disorder. Staff had been listed to attend and their attendance was checked. Staff from the MDT told us staff and people who live in the home will also pop into their office to discuss particular issues. During our

Good

Is the service effective?

inspection we observed people approach MDT members and talk to them in an open and friendly manner. We found MDT members were accepted by people in the home as members of their care team.

We saw clinical case discussions and formulation meetings had been held to discuss people in the home and staff had been invited to attend. Keyworker meetings were in place to support identified key workers and there were Positive Behaviour Support Focus Groups led by the psychology team around specific people. For example staff were invited to one such group to look at what actions can be put in place when a person became distressed. We saw a person was found to have greater focus for the day when they carried out a certain activity on a morning. We observed a member of staff carrying out this activity during our inspection. This meant people were treated as individuals and arrangements were put in place to ensure the service was effective for those living in the home.

We also found additional expertise was sought when needed, this included a person from the Prader Willie Syndrome Association working with staff and relatives to best support people with the syndrome. During our inspection staff explained to us they were covering for each other whilst some staff were doing NVQ work in the meeting room with an assessor. This meant staff were provided with a range of learning opportunities and support based on best practice models of care.

Good

Is the service caring?

Our findings

People spoke with us about the staff approach to them. One person said, “The staff are kind. They don’t shout”, and ”They take me to see my family.” Another person said, “I like my staff they are nice. I am happy today.” One person told us how they have a close relationship with their keyworker and said, “Staff are kind. Staff know what they are doing, they help me. Staff are like my little family.” Another person said, “Staff are kind, I like them, they are helpful. We have meetings about my care. My Mam finds it hard to visit as she doesn’t have a car but the staff take me to see her and pick me up when I’m ready.”

We found people received care and support from staff who knew and understood their history, likes, preferences, needs, hopes and goals and family contacts. We observed the relationships between staff and people consistently demonstrated dignity and respect at all times. Staff supported people in a calm friendly manner and responded to each person’s diverse needs in a caring and compassionate way. When we asked people what did they like best about the service people said ”Having a good laugh with the staff”, and “Doing stuff with the staff.” We found people had a positive relationship with their staff group which promoted their well-being. At the time of our visit people told us they had been Christmas shopping and staff had supported them to choose gifts for their family and friends.

Staff in the home valued and respected people. We saw people were supported to live the life they chose with full regard to their gender, age, race, religion or belief, and disability. They were able to take risks and were not limited by assumptions and beliefs about their diversity. This meant one person worked as a volunteer for a local charity. Another person was enabled to build their own light/sound room close to their bedroom when they struggled to use the home’s communal facility. The person had equal access to an activity they enjoyed in a setting which has been adapted to meet their needs.

The provider had in place an independent advocate who visited the service on a weekly basis and supported individuals or supported people in their house meetings. Their photograph and information about them was displayed in the entrance area. We saw people had spoken to their advocate and found evidence during the inspection of the advocate’s work to ensure people’s voices were heard and acted upon.

The service involved people in the running of the home. One person told us, “I’m the house chairman. I make sure everyone is happy. We have house meetings once a month to discuss things and sort days out and Xmas.” Another person confirmed the house meetings took place and said, “We say concerns and talk about visits.” We saw these meetings were minuted and staff had listened to people and provided explanations. This meant people who used the service played a meaningful ongoing part in the service provision.

We saw the registered provider had in place a training kitchen to support people to gain independence skills. During our inspection people used the kitchen and shared their baking with us. One member of staff described their approach as, “Helping people be more independent and making sure things are right for them.” We found people were engaged in the kitchen and appeared to be enjoying using their skills. We observed one person sharing their baking and staff reinforced how well the person was doing in the kitchen.

During our inspection people who lived in the home chose to speak to the inspection team. We observed staff support people to have the conversations. One staff member interpreted what a person was saying whilst another explained to the inspector about a person’s use of language and how best to communicate with them. The staff were able to involve people in the inspection and provide them with information about our role and functions.

We observed staff give people privacy when they wanted to go in their bedroom. Staff knocked on people’s doors and asked people through the door if they could enter. This meant people were afforded privacy whilst staff maintained a supervisory role.

We found people’s human rights were protected. For example a member of staff explained the measures that were taken in order to ensure that people were able to stay in contact with their families, visiting them when possible, even when they lived some distance away. The registered manager had introduced a keyworker role to the staff group entitled ‘Family Liaison.’ The defined tasks for this

Good

Is the service caring?

role were to provide links with family members so that people in the home could sustain family relationships. This meant the home was promoting people's rights under Article 8 of the Human Rights Act 1998: the right to respect for private and family life.

Good

Is the service responsive?

Our findings

We found the service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and friendships. The service enabled people to participate in a range of activities within the home and in the community and actively encouraged.

people to maintain hobbies and interests. One person told us they were going to a concert in Newcastle that night and they had plans on their calendar to go to other concerts. Another person said, "I like to go out to the shops – I haven't been here long but we are going to get some stuff for me to do: sorted". One person told us about how they are supported to go places, they said, "I like shopping, I like to go into town, the local shops, all over, Home Bargains this afternoon. I like to go out – I've done all me Christmas shopping – but sometimes it's too busy and too noisy. I went to Flamingo land and it was good". One other person we spoke with said, "I do loads, I go everywhere, I have a girlfriend and I see her on Wednesdays at the disco." They went on to explain where their girlfriend lived and how they have contact with her as well as their family members over Christmas. One staff member told us, "There is a good range of activities in the house. Also we have a lot of community access; we have a bus and car available. People use local buses and it's not far to walk to the town or local shops." During the day people were regularly accessing the local community with support from staff.

We looked at people's care plans and found they were well organised and clearly indexed. In each person's file we found there was a 'Quick Reference Guides'; these were profiles of people who used the service and were available for staff who were new or unfamiliar with people in the home. We asked one person who was standing next to us if we could have their permission to read their file. They went along the corridor to their room and returned with their file. Staff explained the person liked to keep their records in their room. This meant people could if they wished look after their own care file and had access to their plans.

Each person's care file included a section on the people who had helped the person to draw up their care plans. This meant people were partners in their own care and their care plans were drawn up with them at the centre of the planning process. We saw people's care plans were entitled, 'My person centred plan' and sections of people's file were entitled, 'My mental health', 'My living skills', or 'My relationships and social networks'. We found this approach to people's care plans encouraged staff to write them in a person centred manner. The registered manager told us this was work in progress to complete everyone's care plan to this level. On reading each care plan we were able to identify people's needs and understand how they liked to be treated. Staff told us they liked the new care plans and found them easy to read and understand people's wishes.

There was evidence that care plans were regularly reviewed and the reviews informed the MDT meeting who in turn were able to respond to the latest issues. The registered manager gave us an example of where a person's mental well-being seemed to be deteriorating, this was picked up and time was spent with the person to look at events and activities which they could look forward to. The person told us about their planned attendance at concerts.

Each person's file contained 'Hospital Passports'. These were prepared to go with residents should they need urgent medical treatment and ensured if there was a transition between services other professionals would have information they needed to treat the person.

Active support was the approach being used in the home to encourage and support people's engagement in activities. Active support is a person centred approach which ensures people are engaged in and can participate in all areas of their lives. Since our last inspection we saw activity levels were monitored and had increased in the home. Staff told us they were aware of what was required of them and were able to follow the activities planning to ensure people were involved either in group or personal activities. The overarching activities programme was changed on a regular basis whilst also providing continuity of some activities for example swimming which gave people choice about what they wanted to do. People were therefore engaged in making individual decisions and were supported by staff to carry out those decisions. We saw people willingly engage in activities during the day.

Each person was supported using a personalised intervention plan formulated at the MDT meeting. Three or four people were reviewed each week. The intervention plans were reviewed and updated at MDT meetings where issues or concerns were examined; plans were put in place to be carried out by named responsible persons with outcome measures identified. The issues or concerns varied between people and included community access,

Good

Is the service responsive?

development of skills, integration in the home, and daily routines. By addressing these issues or concerns the service enabled people to achieve their goals, follow their interests and be fully integrated leisure activities.

We saw the registered provider had in place a complaints policy which directed the registered manager on how complaints should be resolved. We found the registered manager had followed the guidance and resolved complaints. People told us if they had a complaint they would speak to the staff or the registered manager. One person said, "I don't have any complaints really, normally I'm quite happy". We found people felt assured their complaints would receive an appropriate response.

Good

Is the service well-led?

Our findings

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. Since our last inspection the acting manager had subsequently been appointed as the permanent manager and was now the registered manager with CQC.

People who used the service and staff who work in the service told us about the registered manager. One person said, "[Name] is the manager I have no complaints, I just ask and they sort things out". Another person said, "[Name] is the boss and I get to chat to him- he helps me do all I want." We found people were able to recognise the registered manager and felt they could approach them. One staff member said, "Yes I think it's well led – The manager is approachable and I feel supported." Another member of staff told us they felt the registered manager was the best manager they had experienced. Another staff member felt they worked well with the registered manager and had been able to develop. One staff member told us they had noticed considerable improvement in the management and leadership of the unit. We observed an easy rapport between staff and the registered manager, and service users and the registered manager.

The service was the regional winner of the Great North East Care Awards, for their work in supporting a person with challenging behaviours and health issues, and the service went on to be a finalist in the Great British Care Awards 2015. The service was able to demonstrate how their work had reduced a person's harmful behaviours and improved their health and well-being. This meant the registered manager and the staff had received regional and national recognition for their work.

Following our last inspection we spoke with the registered manager about the Multi-Disciplinary Team (MDT) meeting being a top down approach where decisions about people were not being effectively communicated to staff directly working with people The registered manager told us they had considered our findings had revised the approach of the MDT. Staff, led by a senior carer, were now expected to be engaged in an information gathering exercise to review people's care needs before the senior presented the information to the MDT. We observed a MDT meeting taking place and found this to be the case. People could attend their MDT if they wished supported by staff and external professionals. One person told us they liked to attend the MDT. Decisions by the MDT were taken back to and explained to people who chose not to attend. Staff told us how they accessed the MDT records for each person. We found the registered manager had put in place a process where staff and people had a voice about needs rather than staff or people being recipients of decisions. This meant staff were fully engaged in people's care.

Since our last inspection the registered manager had arranged three development days for all staff to attend. During the development days they asked staff to consider service specific values to build on those of the registered provider, the Huntercombe Group. The new values were divided into six areas – respect, family and friends, independence, community, opportunities and choice and control. The registered manager explained these values were shared by the staff. We saw the values had been printed and displayed throughout the home so that all staff and people who used the service could understand the values. We saw the values in action, for example people were given opportunities to follow their interests and their independence was promoted. Staff confirmed they had participated in the development of the values and told us they understood them. This meant the registered manager had engaged staff to develop the home's values which underpinned their practice, and the values had meaning to staff.

During our last inspection we spoke with the registered manager about the number of staff who cared for each person in a month resulting in a lack of consistency of care. The registered manager since our inspection told us they had reflected on this lack of consistency in people's care and considered research in this area by Professor Jim Mansell. This had led the registered manager to arrange the service into, 'Pods'. In each pod there were three or four people who used the service cared for by up to 12 staff. This meant there was increased consistency in people's care and staff needed to be aware and only learn about three of four people's care needs in depth. This also meant the registered manager had taken seriously one concern highlighted by the CQC and utilise research to improve people's continuity of care. Using this approach the registered manager found further benefits included staff knowing who they were caring for when they came on duty

and an increased cooperation between staff to care for people. Staff were able to reflect back to us the ethos of pods as described by the registered manager. One staff member reported to us if a member of staff went off sick in a particular pod this often left them one member of staff down. One person told us they liked being in a pod, "Because I have the same staff". They also told us they liked being in pod 1, "Because it is the best". Each pod had identified risks where some people were identified as high risk to themselves or others and a member of staff needed to be with the person all of the time. The service had identified where staff needed to carry an alarm to alert other staff they needed urgent assistance.

We found the registered manager had worked with the occupational therapist employed by the service to implement the Active Support model of care in the home. Active support is a method by which people are supported to be engaged in activities which improve their lifestyle and well-being. The service had designed a structure which included a mixture of group and individual activities people could do each day. Staff in their pods knew what was required and were able to decide when they came on duty who would support which people to carry out their activities. One member of staff stated the activity rates had increased because staff could support each individual's interests such as cooking, swimming and other community based activities. We saw the service monitored people's participation in activities which had increased. The registered manager told us this initiative was person-centred, but also aimed to prevent staff burn-out and reduce sickness because staff knew who they were working with when they came on duty. Furthermore we observed people asking about their activities and were willingly participating in them. This meant people had developed expectations of participation in activities. We found these arrangements had steered a cultural shift in the home; the home had a calmer atmosphere when compared to our last visit. We found the refocussing by the management of activities being delivered through staff had improved the outcomes for people.

The implementation of the Active Support model had been recognised by the College of Occupational Therapists who had published a paper based on the work of the service. On the first day of our inspection the registered manager and the occupational therapist were presenting their work to occupational therapists in local NHS services. This meant that how the Active Support model implemented in the home was recognised at a national and local level as good practice. This showed that there was a culture of continuous improvement within the service and good use made of research projects carried out by expert bodies.

The registered manager explained that to enable further support people and encourage more effective staff working they had implemented a number of roles. Each person had a staff member who dealt with their home contact, their medical appointments and evaluated their care plan. The registered manager had written expectations for each role; for example staff who were allocated the role of 'Support Plan and Risk Assessment Evaluator' were expected to ensure all support plans and risk assessments were reviewed on a monthly basis. Staff confirmed their roles to us and explained what they did to work together. This meant the manager had put in place clear roles which supported staff who were given responsibility for aspects of people's care. .

Among the quality audits in the home we saw the provider had in place annual surveys including a relative's survey and a service user experiences survey. The registered manager explained they used an independent professional to conduct the surveys to ensure more accurate responses would be obtained. The survey was divided into different areas. For example area one was entitled 'Where you stay and family and friends' and area four was entitled 'Dignity and respect'. The 2014 survey had been aggregated and the outcome put into a pictorial format which demonstrated people who used the service had been listened to. Any shortfalls were identified and plans were in place to improve where this was necessary. Improvements focused on outcomes for people and were checked against an agreed timescale to ensure that they were put into place in a timely way to improve people's quality of life.

The provider had in place a quality audit which measured the performance of the home based on a number of questions which were applicable to the service. The service was then measured over a number of audit sections. The registered manager explained to us the audit sections and demonstrated where the service had improved and what was required to make further improvements as well as their own future plans to improve the service.

The registered manager told us due to the changes in the home they had increasingly involved staff in further training and activities outside of their normal hours and Staff were not always able to attend staff meetings. The registered

Good

Is the service well-led?

manager had devised a monthly staff bulletin update which we saw was available to staff on notice boards. This meant the registered manager ensured staff had access to information when they had difficulties attending staff meetings.

We found there was clear partnership working between the service, other professionals and family members. One family member told us how they found the home to be supportive and they had no worries about the service. We saw the service had involved other professionals in people's care when required. One professional told us they found the registered manager's rationale was, "Sound" and they were able to provide clear information when required at short notice for decision making about a person.

We found the records in the home to be clear, well maintained and accessible.