Shaw Healthcare (Group) Limited

Gospel Oak Court

Inspection report

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Tel: 02074246700

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 18 May 2016 and was announced. We gave the provider 48 hours' notice of the inspection as we needed to make sure that the registered manager or another appropriate member of staff would be available to in order for us to carry out this inspection.

Gospel Oak Court is an Extra Care Housing Scheme and is registered to provide personal care to people living in their own flats within the scheme. Extra care schemes are places which enable people to live independently but can access tailor made and flexible care support when required. At the time of the inspection the service was providing care and support to 35 people some of whom were living with dementia or had a physical disability. This inspection was the first inspection of the service since it was registered in June 2014.

A registered manager was in post at the time of the inspection. 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's main office was based within the extra care scheme. On entering the building, we noted it to be clean, warm and welcoming. A concierge was available to open the door and welcome visitors to the building. Guests and visitors were promptly asked to sign in to the visitor's book. Next to the entrance there was a coffee shop which, people living at the scheme, guests and visitors were able to access.

People told us that they felt safe and secure with the staff that supported them with their care needs. Relatives provided us with mixed views and opinions. Two relatives told us that they were happy with the care that people received, where as another two relatives were not so confident and had concerns about timekeeping and the lack of consistency in relation to receiving care from regular care staff.

The provider had a safeguarding policy and had appropriate processes in place to ensure people were protected from abuse. All staff that we spoke with had a good understanding of safeguarding and whistleblowing and knew clearly what steps should be taken to protect people from abuse.

The service had systems and processes in place to support people with their medicines safely. However, the service did not keep records of stock levels of medicines that were not part of the blister pack and were kept in individual boxes within the person's own flat.

Care were detailed and person centred. The service carried out pre-admission assessments and as part of this assessment identified people's individual risks associated with the care and support they required. A risk assessment was completed for each risk identified and clear guidance was provided to care staff so that risks could be minimised or mitigated. This ensured that people were kept safe at all times.

As part of the care plan process a needs assessment was completed for each person so that the service could determine appropriate staffing levels. The registered manager told us about the number of staff employed per shift during the day and the night. We noted that there was adequate staff to meet the needs of the people who required care and support.

Care plans were person centred, detailed and specific to each person and their needs. People's likes and dislikes were recorded as well as information on how they would like to be supported. Care plans were reviewed and updated on a regular basis and were signed by the people receiving the care. Where a person was unable to sign the care plan we saw evidence of relatives or representatives signing the care plan on the person's behalf.

People told us that the staff were adequately trained and skilled to support them with their care. Care staff demonstrated a good level of awareness in specific areas such as safeguarding and the Mental Capacity Act 2005 (MCA) and also confirmed that they received regular training in the topic areas that were relevant to the work that they did.

People and relatives told us that they were always given the opportunity to make their own choices and decisions. The registered manager, care co-ordinators and care staff had a good understanding of the principles of the MCA and how this was to be applied when supporting someone. We saw posters displayed throughout the scheme which identified the principles of the MCA in theory and in practice.

The service supported people to access health and medical support where required. The GP from one particular surgery visited the service on a weekly basis so that anyone with any non-urgent concerns could be seen within their own home. The service also accessed district nurses and dieticians where needed.

There were systems and processes in place to ensure that any care staff that the provider recruited, were safe to work with people. Care staff personnel files confirmed that adequate checks had been completed prior to any care staff starting work.

We saw positive interactions between care staff and the people they supported. People were treated with dignity and respect. Care staff knew the people they supported and provided them with assistance where required as well as ensuring that people were encouraged to build and retain their independent living skills where possible.

We looked at the complaints policy and the records that the service kept when a complaint was received. Complaints received were responded to, with a clear audit trail of the actions taken and the outcome of the complaint. People and relatives that we spoke with told us that if they had any concerns or issues, they knew who to speak with to get them resolved.

The service asked people to complete annual quality questionnaires. The survey was last completed in March 2016. Overall, positive feedback was noted. The provider also had a number of audits and checks in place to monitor the quality of service provider. Action plans had been developed in order to address the issues that had been identified and to ensure improvements were made as a result.

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. Care staff were aware of the different types of abuse and how to protect people from abuse. Care staff had a clear understanding of the steps to be taken if abuse was suspected and whom this would be reported to.

Systems and processes were in place to ensure the safe administration of medicines. However, the service did not keep records of stock levels of medicines that were not part of the blister pack and were kept in individual boxes within the person's own flat.

Each person receiving a service had detailed and personalised risk assessments in place which identified the risks, the consequences if the risks were not managed appropriately and the actions to be taken to reduce or mitigate the risk.

Staffing levels were determined by the number of calls that required covering and people's level of needs. However, some relatives told us that they felt there could be more staff available.

Is the service effective?

Good

The service was effective. The registered manager, team leaders and care staff had a good understanding of the principles of the MCA and how this was to be applied when supporting someone.

Care staff that we spoke with told us and records that we looked at confirmed that all staff received regular training which was classroom based as well as through e-learning.

Staff received regular supervision meetings in line with the provider's policy.

People had access to health and social care professionals so as to receive appropriate care and treatment.

Is the service caring?

Good

The service was caring. People told us that they were treated with kindness and compassion and we observed interactions between people and staff to be respectful and person centred.

Care plans that we looked at confirmed that people were involved in making decisions about their care and staff took note and acted upon people's individual needs and preferences.

People's care plans were person centred and detailed and included people's preferences, likes and dislikes. People's independence was promoted.

Is the service responsive?

Good

The service was responsive. A complaints policy was available and displayed around the scheme outlining how to complain and how the complaint would be dealt with. People and relatives told us that they were able to complain and felt confident that their complaints would be dealt with appropriately.

People received personalised and responsive care according to their needs and requirements. Care plans were person centred and detailed people's likes and dislikes and noted their preferences on how they would like their care to be delivered.

People's religious and cultural beliefs were recorded within their care plan. A monthly church service took place, which people were encouraged to attend if they so wished.

Is the service well-led?

Good

The service was well-led. People and relatives knew who the manager was and were able to approach them and the team leaders if they had any issues or concerns.

The provider had systems in place to monitor and audit systems in order to improve the quality of care provision.

Annual quality surveys were sent to people and relatives to complete and give feedback in order to learn and improve the quality of care provision.

Staff told us that they felt well supported by the registered manager and worked well together as a team.

Gospel Oak Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 18 May and 19 May 2016 and was announced. The provider was given 48 hours' notice as we needed to be sure that the registered manager or another appropriate staff member would be available to support the inspection process.

The inspection was carried out by a single inspector 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. The inspector visited the service and the expert by experience made phone calls to people who used the service, relatives of people who used the service and staff members to obtain their feedback about the service.

Before the inspection, we checked the information that we held about the service and the provider including notifications and safeguarding concerns affecting the safety and well-being of people. We also contacted the local commissioning team and a number of social workers in order to obtain their feedback about the service and the provider.

During this inspection we observed how the staff interacted with and supported people who used the service. We spoke with four people who used the service, four relatives, the registered manager, three care co-ordinators and three care staff.

We looked at six care plans, five staff recruitment files, training records and records relating to the management of the service such as policies and procedures, audits, medicine records and risk assessments.

Good

Is the service safe?

Our findings

People told us that they with felt safe with the care staff that supported them. One person when asked whether they felt safe told us, "Yes. Very happy. I get well looked after." Another person said, "I feel safe enough." Two relatives that we spoke with were not as positive or assured that the people who received care were safe. Feedback received raised a number of issues around consistency and the provision of regular staff and that staff do not answer the emergency call bell in a timely manner. However, during the inspection we were unable to find any evidence to support these claims. A third relative told us, "Every time I've gone to visit, the flat is always spotlessly clean. The accommodation is superb and there's plenty of food in the fridge and freezer. Overall I do think she's being well cared for." We spoke with the registered manager about the comments that we had received who noted the concerns and assured us that they would address these issues immediately. The day after the concerns had been highlighted the registered manager sent us a report investigating the issues which included details of the actions taken.

A safeguarding policy was in place which described the different types of abuse as well as indicators that care staff should look out for to identify abuse. The policy gave clear directions and guidance about the actions that staff should take if abuse was suspected. Care staff that we spoke with had a clear understanding of the different types of abuse and the actions they would take if abuse was suspected. One care staff member told us, "If I see any bruising or changes in attitude, I would report to my manager." Training records that we looked at confirmed that staff had received training in safeguarding.

Care staff were aware of whistleblowing and were confident about raising concerns about any poor practises witnessed. Staff knew that they could report their concerns to the local authority and the Care Quality Comission (CQC). We observed that the service had displayed posters in different areas of the service about whistleblowing, what this was and who to contact.

The registered manager kept detailed records of all safeguarding incidents that had been reported. We saw that following an incident, an internal investigation had been carried out. This included details of the incident, the actions taken and the outcome of the incident with any learning that had taken place.

The provider had policies and procedures in place for the safe management and administration of medicines. Policies and procedures available provided guidance to staff on ordering medicines, receiving medicines, administering medicines, disposal and returning of medicines and recording of medicines on the Medicine Administration Record (MAR). Each person's medicines were kept in a locked cupboard within their own flat and contained all of that person's prescribed medicines. Senior care staff who were known as 'floaters' held the keys for the cupboards and were the only staff members that had access to these cupboards.

Within each cupboard a poster was on display which outlined the seven rights of medicine administration. This gave guidance to care staff on how medicines should be correctly administered taking into consideration the time, ensuring the correct medicine and dosage were administered and the method of administration. We looked at a number of MAR's and found that there were no unexplained gaps in

recording. People had been prescribed as and when required medicines (PRN). A PRN protocol was in place which outlined the medicine, when and how it was to be administered. A number of people had also been prescribed controlled medicines. These are medicines which are defined as controlled under the Misuse of Drugs Regulations 2001 because there is a higher risk of abuse of these medicines, risk of them being obtained illegally or causing harm. We checked stock levels of the controlled drugs and found them to be correct according to what the home had received from the pharmacy and what had been administered.

However, the service did not keep records of stock levels for some medicines that were not part of the blister pack. This included pain relief medicines, medicines to help with constipation and certain medicines that could not be kept within the blister pack which included prescribed medicines and homely remedies. We also noted that where some people's medicines had been received outside of the monthly cycle and where entries onto the MAR had to be handwritten, these had not been signed by two people to confirm that the written entry was correct in relation to the dose to be administered and the direction on how the medicine should be administered. We highlighted this to the registered manager who confirmed that they would ensure that these processes would be completed going forward.

One person had been prescribed a specific epileptic medicine which was to be administered if the person suffered two recurrent epileptic seizures, or if a seizure lasted more than five minutes. There were appropriate risk assessments in place giving specific direction and guidance to staff on how and when this medicine should be administered. Due to the potential dangers of this medicine, anyone who administers it must have completed specific training in its safe use and administration. The service had provided this training and care staff that we spoke with confirmed that they had attended this training and we also saw certificates confirming this.

Senior staff members completed daily medicines audits to check that people's medicines had been administered correctly and that staff had signed all the necessary records. The audit was recorded on a chart which included the name of the staff member administering the medicine and the time medicines were given.

Staff records that we looked at confirmed that most staff had received training in medicine administration which included a competency assessment which care staff were required to complete once they had received the training. Where care staff were yet to complete the medicine training as they were new and had just started work, they were unable to support people with the administration of medicines.

We asked people and relatives about medicines and whether people received their correct medicines and on time. One person told us, "It's given at the right time." One relative that we spoke with told us, "She wasn't getting her medicines correctly, but this has been resolved."

The service had a risk assessment policy in place. Care plans that we looked at included risk assessments which identified people's individual and personal risks. Risks identified included personal care, finance, smoking, urinary tract infections and pressure sores. Assessments included details of the risk identified, the consequences if the risk was not managed and the actions to be taken to reduce or mitigate the risk. Risks were graded as low, medium or high based on a calculation which looked at the likelihood of the risk occurring and the consequence of the risk. Care staff that we spoke with were aware of people's risks and how these could change very quickly. One care staff member told us, "Care plans are very detailed and identify risk. If there are any changes the office is quick to make the changes and let you know of the changes made to the care plan."

All accidents and incidents were recorded on an incident form. The form included details of the person, the

date, time and where the incident took place, what the outcome was and what immediate steps were taken to prevent the incident from re-occurring. The registered manager had oversight of all incidents and accidents and a monthly report was compiled which noted any trends and patterns and was presented to senior managers and the local authority for their information.

The provider had appropriate systems and processes in place to ensure safe recruitment of staff. Recruitment records showed that enhanced criminal record checks had been undertaken prior to a staff member commencing work, two written references had been obtained and proof of identity and the right to work in the United Kingdom had also been obtained. The registered manager told us that all recruitment applications received were scrutinised by the central human resources (HR) department. This also included a separate form which a potential employee was asked to complete which identified any gaps in a potential staff member's employment and the reasons for these gaps.

Where a staff member had restrictions placed on their legality to work in the United Kingdom the central HR department kept a record of this and for example when a visa was due to expire the HR department would inform the registered manager who would write to the staff members requesting an update and confirmation of their legality to work in this country.

The registered manager told us that they occasionally used agency staff from an external source. The service had a folder which included agency staff profiles, a completed induction checklist which the provider undertook with the agency staff member, details of their training and the date their criminal records check had been undertaken. The registered manager told us that they used the same agency to ensure that they received regular and consistent care staff who had got to know the people who required support.

We looked at the staff duty rotas for the last four weeks. The registered manager told us that they tried to set rotas four weeks in advance and care staff received their rotas one week in advance. The registered manager was in the process of trying to allocate regular carers to a regular set of people on a rolling basis. This was to ensure that each person received a regular set of carers on an ongoing basis.

The registered manager explained how staff were allocated on each shift. Staffing levels were determined based on the number of staff required as per the total number of shifts that required cover. Staffing levels were also determined based on people's level of needs. Where a person required additional support measures would be put in place to allocate additional staff dependent on the individual needs of that person.

However, two relatives that we spoke with felt that staffing levels was an issue. One relative we told us, "One of [My relatives] has 24 hour care [private] but [My other relative] gets all his care from Gospel Oak and sometimes they are short of staff, which means he probably wouldn't have a shower. Sometimes the carers stay the full time, at other times they don't turn up at all, especially at weekends." Another relative told us, "I think they're short of staff as far as I can tell. There's no permanency; the staff are always changing. The accommodation is beautiful, absolutely, very modern but the service is lacking/wanting. I do know they're busy. Sometimes they are late." The manager was informed of these concerns following the inspection. The service had an on-call system whereby an allocated senior staff member would be responsible for the mobile phone so that when someone rang their emergency call bell the allocated staff member would be alerted and would call the person immediately to confirm whether the person was okay and what support or assistance they required. However, the system did not log or print the details of the emergency call, when it was activated and how long it took staff to respond. We spoke with the registered manager about this who told us that if there was a concern raised by people using the service or relatives they would be able to obtain this report from the company who manages and maintains the emergency system.

The service maintained weekly fire bell checks, two weekly fire alarm checks and quarterly scheduled fire drills. A grab bag was available within the main office of the service which contained personal emergency evacuation plans for each person living at the scheme along with a business continuity plan and contact details for relevant people and services to be contacted in case of an emergency.

All care staff had full access to personal protective equipment (PPE) at any time when required. We observed that care staff were able to come to the office and collect whatever supplies that they required.

Good

Is the service effective?

Our findings

People told us that they were supported well by carers who knew what they were doing. One person said us, "I feel that they look after me." Another person told us, "The carers are alright, they do what you ask them to do." Some relatives that we spoke with were not so positive and did not feel that staff were adequately trained to do carry out their role. One relative told us, "I would say 'No'. For example, questions are not put to [My relative] in a way that he can process, they don't give him time to think about what's been asked. If staff cover is over a mealtime and [My relative] doesn't eat, they'll throw the food away and not wait for the private carer to return, to ask their advice." Another relative told us, "To tell you the truth, I don't think so. I don't think the staff are well trained." However, a third relative did tell us that although they have reservations about the training that staff receive, when they have visited the person receiving the service they were happy with what they saw.

Care staff told us that they received regular training which was classroom based as well as through e-learning. One care staff member said, "Training has been good and I feel able to make suggestions about training that we require and this is provided." Another care staff member said, "I have been through all the training such as dementia, Parkinson's, first aid, food hygiene and Mental Capacity Act. If we have a query and need to be updated on things the manager will get it sorted."

Training records that we looked at confirmed that staff had completed training in a variety of areas including health and safety, fire and person centred care. Training records showed what training was available, and documented the name of each care staff member, the course they had completed and the date of completion. Care staff files that we looked at also confirmed that each staff member had undergone induction training before they started work. This covered topics including basic care, code of conduct, record keeping and safeguarding. The registered manager told us that they would be delivering the care certificate for all new care staff recruited. The care certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support and is covered as part of induction training.

Care staff that we spoke with told us that the manager and team leaders were very supportive and enabled them to carry out their role effectively. One care staff member told us, "We receive supervision every six weeks. The new manager co-operates and at any time he is available to talk to you if you have any problems." Another care staff member said, "Yes I do feel supported." Supervisions were recorded and we saw evidence of these on the staff files that we looked at. Care staff were beginning to receive annual appraisals because the service was relatively new.
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.

The service had a MCA policy in place which outlined the key principles of the MCA. Posters were also

available around the scheme which outlined the principles of the MCA. We spoke with the registered manager about the MCA and Deprivation of Liberty Safeguards (DoLS). The registered manager explained to us that people were able to leave the scheme as and when they chose, but if someone was unable to do so independently, the service would ensure that a care staff member was able to accompany them to ensure their safety and that they were not being deprived of their liberty to go outside.

Team leaders and care staff members that we spoke with had a good understanding of the principles of the MCA and were able to explain the actions they would take if a person's capacity was fluctuating. One care staff member, when asked about their understanding of the MCA, told us, "I give people choice in relation to clothes, meals, what they prefer. If someone is refusing personal care, I would give it one day and then I would go to my team leader and get them to prompt or try. The team leader would then make the decisions about reviewing the care and would get in touch with social services and then get the appropriate permissions." Another care staff member told us, "We have to protect people that lack capacity. Always assume people have capacity but if someone cannot make a decision always give them a choice, an easier to understand option. I would inform the office if someone's mental capacity had changed."

People and relatives told us that staff always asked for permission before carrying out any tasks. Care plans evidenced that consent to care was obtained and where possible care plans were signed by people. Where people were unable to sign, a relative had signed on their behalf. People told us, "Washing and that, yeah, yeah, they ask permission. They ring my daughter or whatever if they need to" and "They always ask my permission." During the inspection we observed care staff obtaining consent in areas such as entering the person's flat or what they would like to eat or drink.

The service provides care services within an extra care scheme. The service was not involved in menu planning for people as many of them either prepared their own meals or were able to make choices and order ready-made meals which were delivered to their flat. Care staff members would then assist people to prepare some elements of the meal or support with heating up pre-ordered meals. The registered manager had recently carried out a survey to see if any of the tenants within the scheme would like to receive a hot meal, which would be provided by one of the providers sister services, a care home situated next door. Tenants would have to pay for this service. A sample menu was provided. A mixture of responses was received and the registered manager was analysing the responses.

Care staff members were not always able to monitor peoples' food and fluid intake as they were only available at the person's home for a limited period of time and in some instances only once during the day. However, if staff did have any concerns about a person's poor food and fluid intake, these were noted in the daily record notes and highlighted to the team leaders and/or family members. We also noted that for one person where their food and fluid intake was a concern, care staff members were completing a food and fluid intake chart which was monitored by senior carers and team leaders. We also noted that referrals had been made to the relevant health professional.

We spoke with people about the support they received from care staff in relation to shopping and mealtimes. One person told us, "My daughter does me shopping. I can choose what I want to eat." One relative told us, "I don't know why she's losing weight, but she appears to eat well. [My relative] has reported that the food is nice, but I don't know the portion sizes. I've witnessed someone asking [My relative] what she wants for her tea."

People were supported to maintain good health and had access to healthcare services and received ongoing healthcare support. Care plans detailed people's health and medical needs. People were able to contact the GP or nurses themselves when they required support, where possible. However, one GP surgery,

with whom the service worked very closely with, carried out weekly visits to the scheme. A GP log book was kept on a daily basis and if someone needed to see the GP for a non-urgent concern, it would be logged in the book for the GP to take note of when they carried out their weekly visit. All urgent requests for the GP were submitted on the day and a visit normally took place immediately.

We saw records of referrals to health services where people needed support with pressure area care or needed to see the dentist or chiropodist. One person when asked if they received medical help when needed told us, "Well, they got the doctor in." A care staff member told us, "We had a lady who used the standing hoist but one day was unable to use. We reported this to the office and the next day an occupational therapist visited and re-assessed the lady an now we are using a full body hoist. Staff really know the people and every time we report to the office they take action immediately."

Good

Is the service caring?

Our findings

People that we spoke with were very complimentary of the care staff and the service that they received. One person told us, "They are hard as diamonds but gentle as cotton wool." The same person also said, "If everyone is laughing that must say something." Another person told us, "Oh yeah. They're very kind to me." A third person stated, "We have a laugh and a joke and we talk to each other as friends, they are very caring."

Relatives that we spoke with told us that staff were caring and respectful. One relative said, "Every time I've been, they've been very caring. Very sociable and chatting with her." Another relative told us, "Some are excellent, but they've had so many manager changes. Some are brilliant, others are very slipshod in their manner. It could be to do with time."

Care staff members that we spoke with spoke respectfully about the people they supported and were very dedicated to the work that they did. One care staff member told us, "I enjoy working with people. There are some real good characters here. It doesn't matter what we are paid, if you are doing this job for money then you shouldn't be here. It's about treating people as you would treat your friend but in a professional way."

We observed interaction between staff and people who used the service during our visit and saw that people were relaxed with staff and were confident to approach them. Staff interacted with people in a positive manner showing them kindness and respect. We observed people to have free movement around the scheme and could choose where to sit and spend their recreational time. A coffee shop was situated on the ground floor of the scheme where people could go down to socialise with other people. The service provided a variety of reading materials including a number of daily newspapers and magazines.

The registered manager carried out regular walks around the scheme, especially checking on those people who were unable to leave their flats due to ill health or physical disability. These walks were not recorded, however if there were any actions to be taken these were recorded in the handover record or the communication book.

Care staff knew the people they supported well. They were aware of people's likes and dislikes. Care plans were person centred and contained detailed information about their preferences and wishes on how they wanted to be supported by care staff. People's views regarding end of life care and their wishes had been recorded.

We saw evidence that regular reviews of care were taking place and that any changes were recorded within the care plan. Relatives that we spoke with told us they felt involved with the care that people received. One relative told us, "Yes, the initial cover [My relative] was given was not enough, so we had a meeting and agreed a further care plan."

People told us that they were treated with dignity and respect at all times. One person told us, "They give me a shower and that. They shut the bathroom door. They're very private." Another person told us, "They always

knock on the door and ask 'can I come in?'." We noted on care plans that people were asked their preferences about whether they would like a male or female care staff member to support them and their preference was recorded within their care plan.

Relatives also made comments about whether they believed people using the service were treated with dignity and respect. One relative told us, "She's definitely given privacy, I think so. If they change her, they shut the door and that. They would make sure her son wasn't there."
Another relative stated, "Yes, I do believe, as far as I know. She's washed regularly by ladies. I don't know who deals with her at night. But she's never complained about that."

Care staff were very aware of supporting people in maintaining their independence. One care staff member said, "Care is about promoting independence. I give them choice and encourage them to things themselves. I look at different ways of helping them for example where someone needs to put on their trousers, I get them to sit down and do it so that they don't lose their balance." Another care staff member told us, "Promoting independence by encouraging them. I like to chat to them. Respecting people's privacy and dignity is my duty."

We spoke to the registered manager and three care staff members about supporting people who were lesbian, gay, bisexual or transgender (LGBT). Care staff told us that LGBT people used the service. One care staff member told us, "I don't have to neglect or discriminate against them, it's their choice. I cannot judge regardless of religion or sexuality. We have to give equal rights to all of them." Another care staff stated, "It makes absolutely no difference to the care that is provided."

Good

Is the service responsive?

Our findings

The service had a complaints policy in place which gave guidelines to people on how to complain, who to complain to and the timescales in which their complaint would be dealt with. A complaints protocol and the policy were seen displayed around the scheme. A complaints folder contained details of each complaint the service had received. Each complaint had a record of the actions taken to deal with the complaint and the response that was provided to the complainant.

People and relatives that felt able to raise any concerns or issues and felt confident that these would be dealt with. One person when asked if they knew who to complain to told us, "Yeah, the manager. Oh yeah, they would help me." Another person told us, "If you have a problem they sort it out immediately. Most things are resolved within 10 to 15 minutes. Efficiency is quite outstanding." Relatives' comments included, "I tend to go to the team leader and sometimes direct to the manager" and "I know the manager and feel able to raise issues which have been dealt with."

We asked relatives whether they felt that the person being supported was listened to by the care staff. One relative replied, "I would say partially, not whole-heartedly. It depends who the carers are. Some are sympathetic and listen to her and do what she wants. Others are indifferent to her requests." Another relative told us, "I do believe, generally yes. Yes."

The service kept records of all compliments that were received. One comment included, "Whilst writing, may I just say that I think that Gospel Oak Court is an outstanding care home. The carers are wonderful and look after [My relative] in a quite admirable way."

People received care according to the details recorded within their care plan. A pre-assessment form was completed prior to a service being provided to ensure that the service was able to meet the person's needs. Care plans were noted to be personalised and responsive in order to meet people's needs and requirements. Care plans detailed information about people's background, their likes and dislikes and a summary of their health and well-being. Care and support plans were in place for areas such as personal care, maintaining and making relationships, continence, mobility and medicine management. We noted that people had signed their own care plans agreeing to the care and support that they received. In some cases where people were unable to sign their care plan, relatives had signed on their behalf.

Care staff used daily recording notes to record how people and been supported and any specific observations or concerns that they had noted so that the next care staff member attending to the person had a clear handover of how the person had been and any specific care or support needs that needed attention. We noted that daily recording notes were person centred and not only noted the tasks that had been undertaken but also included details about care staff 'chatting' with people and ensuring that their nutrition and hydration was maintained.

Care staff knew what person centred care was and how this should be delivered to the people that they support. One care staff member told us, "I greet the person in the morning and give them time to express

their feelings." Another care staff told us, "I get them to socialise, I try and get most of them out of their room and get them involved."

Some care staff took on the role of activity co-ordinator and arranged a variety of activities for people to attend. We saw an activity poster on display around the scheme for the month of May 2016. Activities included music, dancing, fish and chips day, tea and scones afternoon, video afternoons and dominoes. On the day of the inspection the service had organised an information session about dementia which was organised and delivered by the Alzheimer's society. Joint activities with the providers sister service, located next door, were also held which included external entertainers who were invited to the scheme.

People's religious and cultural beliefs were recorded within their care plan. A monthly church service took place, which people were encouraged to attend if they so wished. One relative told us, "I think a vicar comes to visit [My relative]. Her love is colouring in, which she can do on her own. She loves her music. She's got a reclining chair to watch TV." The registered manager also told us that some people went out to attend day centres which had been arranged through the local authority.

Good

Is the service well-led?

Our findings

People knew who the manager was and were positive about the way in which the service was managed. One person told us, "This is a house full of integrity and honesty from the start. We can't do without him [registered manager]." Another person said, "I think he's very nice."

Relatives we spoke with overall were positive with the manager and the way the service was managed. One relative told us, "I think he's trying extremely hard; he's fairly new. Things I've taken to him, he's tried to deal with. He does follow it up." Another relative said, "I know it's [name of manager], but I've not met him. He sounds alright on the phone. He sounds affable and willing. They all listen and say it'll be looked into, but no, nothing is looked into."

Care staff spoke highly of the registered manager and team leaders. One care staff member told us, "[Name of manager] seems very proactive, especially with activities, he is very approachable." Another care staff member said, "The new manager is trying his best." We observed the registered manager, team leaders and care staff working together as a team. One care staff member told us, "I'll help my team."

We saw that dates for staff meetings had been set for the year by the registered manager. A meeting was scheduled for every month. The last meeting was held in April 2016 and minutes were available for this meeting. Topics discussed in the meeting included rota's, wages and care of service users. Care staff that we spoke with confirmed that regular monthly meetings did take place. One care staff member told us, "Staff meetings are held once a month. You can discuss and raise issues and concerns." The registered manager also held monthly team leader meetings. Agenda items included policy matter, training and development, safeguarding and local news.

The owner of the building, in conjunction with the service, held tenants meetings so that tenants were involved in the running and management of the building. The last meeting held was in December 2015 and agenda items included rent, property inspections, complaints and activities. One person told us, "Sometimes I go down to meetings. We had one the other day to talk about whether there's anything wrong with the flat."

A quality assurance policy was in place which outlined the provider's quality assurance programme for the year. The programme consisted of bi annual quality reviews, two monthly management reviews and a quarterly internal quality audit. We saw evidence of these audits taking place. The two monthly management reviews were completed by the provider's area manager. We saw that two audits had taken place since the beginning of the year and covered areas such as environment, care plans, safeguarding and complaints. An action plan was available for the issues that had been identified and a colour coding system was in place to highlight what action had been completed or was in the process of being completed. The registered manager was working through the action plans that had been handed over when they started working for the provider. The provider also completed bi-annual quality of life audits. This audit looked at areas including the completion of incident forms, behaviour plans, support plans and medicine management.

The provider also collated detailed information on a monthly basis about care plan audits, reviews undertaken, medicine incidents, falls, admission to hospitals and deaths and compiled a report which was circulated to all senior managers and the local authority. When we spoke to the commissioning manager at the local authority they confirmed that they received very detailed reports from the service and found them to be very helpful. Documents that we saw assured us that the registered manager and the provider had good management oversight of the service.

The service carried out annual satisfaction surveys which were sent to people using the service and relatives. The most recent survey was completed in March 2016. The registered manager told us that in some cases where people were unable to complete the questionnaires, care staff and team leaders supported them to complete the form. Relatives confirmed that they had received questionnaires to complete. One relative told us, "I believe I've completed it and sent it back." Another relative stated, "Yes, I think I did, but I didn't fill it in because I had to ask her [My relative] questions and she didn't want to answer."