Mental Health Care (Hoylake) Limited

Meols Drive Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 and 18 March 2016 and was unannounced. The first person moved into Meols Drive Care Home in November 2014. This was our first inspection of the home.

Meols Drive Care Home specialised in providing nursing care for people with mental health support needs, learning disabilities or autism.

Meols Drive Care Home is in a modern spacious detached building in its own grounds on a residential street in Hoylake, Wirral. The home is registered to provide accommodation and nursing care for up to 12 people, at the time of our inspection 8 people were living at the home.

People we spoke with told us they liked living at Meols Drive and had good relationships with the support staff. Our observations of the staff were that they were caring and treated people with dignity and respect. There was a relaxed and friendly atmosphere at the home, it was not clinical or regimented and people's choices were respected.

The building was designed as a spacious, safe and well equipped environment for people with mental health support needs and or autism. All of the bedrooms at the home were en-suite. The bedrooms on the first and second floor were accessed by a lift. We found the home to be well decorated in a non-clinical and homely style, clean, fresh and well maintained. There had been attention given to the environment, usability of the space and adaptations made for the people living at the home. There were three different communal areas used by the people living at the home along with a computer and craft room and 'skills kitchen'. People living at the home had access to two vehicles, a mini bus and a car. These were used for trips out, appointments and traveling to and from regular places.

There was a separate self-contained annex of the building called the 'flat', this contained three en suite bedrooms, a lounge and kitchen. The manager told us they provided a different type of support for people who are developing their skills and independence. People living in the 'flat' went food shopping and cooked their own food with support. It is planned that this support is a stepping stone for people to move onto more independent living.

We checked a sample of people's medication. We found areas of improvement needed in the administration and documenting of medication, this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The home environment was safe. The manager had arranged for risk assessments, regular audits and checks to take place of health and safety and the home environment. The senior staff had used the relevant professionals to service equipment at the home as necessary.

We found there to be adequate nursing and support staff working at the home. These staff had been safely recruited, inducted and trained. Longer standing staff had received refresher training. Staff were supported with regular supervisions and appraisals with a senior member of staff.

People living at the home were involved in their care planning each month and signed off their care plan if they were able to. The care plans were detailed, clear and written in a person centred way. They contained lots of information about people's different communication styles, health needs and information for staff on how to support people safely and in the way the person preferred. 'Resident's meetings' were held to gain feedback from people living at the home.

At times people did things that may be unsafe to themselves or others and may be seen as challenging to support safely. We found evidence that staff responded appropriately ensuring people were safe. There was also attention given to making sure that any physical intervention was caring in its approach and was the least restrictive method used for the least amount of time. Staff were trained in a recognised technique and received annual refresher training.

There was not a registered manager in place at the time of our 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 organisation had appointed a manager to operate the service who was aware of their responsibility to register with the CQC.

The manager had a relaxed and friendly approach to people. It was clear that he knew the people living at the home well and had good relationships with people. He was understanding and aspirational when speaking about people and their support. The manager listened to people and took their concerns and complaints seriously. He promoted people making choices and made sure people's support and the practice at the home was in line with the principles of the Mental Health Act (2005).

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The administration of medication was not consistently safe.

People living at the home and their relatives we spoke with told us they felt the home was safe.

There were adequate numbers of well trained and experienced staff for the assessed needs of the people supported. Staff were safely recruited and had received safeguarding training.

Safety checks of the environment were made.

Is the service effective?

Good

The service was effective.

People told us they enjoyed the food provided.

Staff received induction and training relevant to their role. They were assessed during a probation period. Longer standing staff received appropriate refresher training.

The environment was suitable for people's needs, adaptations had been made to the environment. People were supported with their health needs.

The support people received was in line with the principles of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

People were listened to, treated with dignity and respect and had been supported through difficult times. People told us they liked the care staff.

People's support was flexible and responded to their wishes and preferences.

The support provided took into account people's feelings.

Is the service responsive?

Good

The service was responsive.

The support was focused on people trying new things and learning new skills. Some people were being supported to become more independent.

One to one support times were flexible.

People care plans were aspirational and detailed. These were reviewed monthly with the person.

Incidents and accidents were documented and analysed.

Is the service well-led?

Good

The service was well-led.

The service did not have a manager that was registered with the Care Quality Commission, however the appointed manager had commended the process.

The manager set a caring and relaxed culture in which people were listened to. It was clear he knew people well and had positive relationships with them, people living at the home were comfortable around him.

Regular 'residents meetings' were held to gain feedback directly from people.

Meols Drive Care Home with Nursing

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 11 and 18 March 2016 and was unannounced. The inspection was conducted by an adult social care inspector.

We spoke with four people who lived at the home who were in during our visits. We spoke with eight staff members, the manager, deputy manager, two nurses, three care staff and the cook.

We spoke with four relatives of people living at the Meols Drive Care Home after our inspection.

We looked at the care files for four people and the staff records for four members of staff. We looked at four people's medication administration records, the medication stock control and audits.

We observed the care and support of people. We spent time chatting with people at lunch time. We looked around the communal areas of the building, a few people showed us their bedrooms.

We checked the records held by the CQC prior to our inspection.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at the Meols Drive Care Home. One person said, "This is my home, of course I do". Another person told us, "All the staff are like family, we get very well looked after here". A third person told us, "They look after me here".

One relative we spoke with said about Meols Drive Care Home, "From what I've seen of it, it's ok. I've never had any concerns". Another told us about their relative, "He's safe and well looked after, they'll do anything they can for him".

We looked at the way that medicines were managed in the home and found a number of concerns. The nurse and manager were not able to demonstrate a robust medication stock control system. When checking stocks there was no carried forward balance of medication at the start of the current MAR chart, or in any other place. This made it more complicated to ensure that adequate stocks were on hand. One tablet that was taken by one person on a four a day basis only had six in stock, therefore going into the weekend without enough stock for Sunday. The nurse and manager were unaware of this, it was late Friday afternoon and no medication had been ordered.

We noticed that one person had missed one of their medications that morning. It was signed as administered but it was still in the blister pack. Another of the same person's medication had one too many in stock, indicating one may have been missed since the MAR chart began.

Another person's medication that was due to be taken once a week was signed for as given two days previously but was still in stock.

A third person's medication the previous evening had not been signed for, it was not in the blister pack indicating it was given and not signed for.

In the medication cabinet we noticed medication in two paper pots. The nurse told us one pot was last nights medication for a person who had refused it and it was awaiting disposal. The second pot was the same person's medication due this morning at 10am that had also been refused. It was now 4:30pm. When looking at the medication there was an additional PRN medication for anxiety in the pot that the nurse had tried to administer that morning. The nurse said this was also awaiting disposal. The two medication pots were temporally stored on the same shelf near a different person's medication and had not been identified or marked in any way. There was a risk of confusing different people's medication by doing this. This was an unsafe practice.

When 'as and when required' (PRN) medication was used there were guidelines in place in people's medication files. Mostly this was well documented. However for one person's PRN medication there was a handwritten MAR with no start date documented, also the date the medication was administered had not been recorded.

These examples are breaches of regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (The proper and safe management of medicines).
We told the manager of our concerns on the first day of our inspection. We told them to arrange for the medication to be audited. By the second day of our inspection this had been done. The manager also told us that medication refresher training for nurses was in place.

We found there were adequate numbers of staff for the support needs of people living at the home. During the day there were two members of nursing staff on duty and overnight one nurse on a waking night shift. In addition to this both the manager and deputy manager were qualified nurses. There was also a team of support workers on duty during the day and night. On the first day of our inspection we observed five support workers on duty, the rota showed four support staff would be on duty during the night. Meols Drive Care Home on occasions uses agency staff to ensure there are enough support workers on duty, agency staff are spread out so there is only one or two agency staff working with permanent staff at any one time.

People at Meols Drive Care Home were assessed for the level of support they needed when out in their community and the rota for staff was adjusted. Some people had been assessed as requiring support from two staff members when out and about. The home made use of assistive technology to keep people safe and alert staff if people needed support. For example people diagnosed with epilepsy had seizure monitors.

Medication audits had been conducted monthly. These were alternated between a member of the nursing staff and the deputy manager. In January the audit had highlighted 6 actions needed that had been addressed.

Health and safety audits were completed by the deputy manager, we observed a schedule of their audit responsibilities and timescales. There was an emergency action plan in place to use in the event of an emergency alongside a personalised emergency evacuation plan for each person.

We looked at the fire safety file. In 2015 there was a full fire risk audit. There was also a fire risk assessment, outlining the support each person would need if there happened to be a fire. This contained a detailed building plan outlining the locations of smoke sensors, firefighting equipment and alarm buttons. The file also documented weekly fire alarm tests that had been consistently documented along with regular checks on fire equipment, door closers and fire door checks. It was checked that the emergency shutters worked which would isolate the kitchen as a potential source of fire in an emergency. The emergency lighting was checked monthly and this was recorded. At the end of each day shift there is a security night time check.

Fire evacuation drills had been completed and an evacuation time of less than three minutes recorded. There was an emergency grab file available with essential information that may be needed in an emergency.

We looked at the property maintenance file. This showed that the lift had been recently serviced. Gas and electrical safety checks had been completed. The nurse call system, emergency lighting and legionella screening had all been checked. Hot water temperatures were checked and regulated by thermostatic valves. There was a contract in place for the safe removal of clinical waste. Monthly infection control audits had been completed, these highlighted areas for improvement that had been acted upon.

The environment showed evidence of being designed to keep people safe in a variety of situations. For people's safety windows had opening restrictors and bedroom doors were of an anti-barricade design,

enabling staff to support people if a dangerous situation arose. The manager told us these had been used only once.

Any incidents and accidents are collected across the organisation and are discussed at the managers meeting and learnt from. The manager showed us how these are stored in a computer program for easy reference and safe confidential storage.

All staff received safeguarding training as part of their induction; longer standing staff received refresher training. We spoke to staff members about safeguarding. One staff member told us they thought it was the, "Main part of their role". The staff we spoke with knew the different forms abuse may take and told us of clues they looked out for which may indicate abuse was happening. The staff knew who to report suspected abuse to and were aware they could go outside of the registered provider if necessary. Nursing and support staff also received training in keeping people safe in challenging situations using a recognised technique (MAPA, Management of actual or potential aggression).

Staff had been recruited safely. In staff files we saw application forms and notes from an interview applicants had attended. Staff files contained either two or three references that the home had sought for people. Applicant's identification was checked and a criminal record check (DBS) had been completed. Any offenses identified were risk assessed to decide if an applicant could be offered a role at the home. Staff had employment contracts with the organisation. New staff were employed on a probationary period, we saw evidence that the staff members performance and suitability was assessed at the end of this period in a probationary review. Nursing staff had their registration (PIN) checked to ensure they were registered nurses, this had been repeated annually.

Good

Is the service effective?

Our findings

One person we spoke with told us, "I love it here, I love the staff here". Another person added, "The staff are all fine". A third person told us the home was "Nice", adding "I have my own fish tank, TV and radio, I like having my own bathroom". We were told by one person that they, "Go out but check what staff we have got".

One relative told us they looked at the environment at the home before their son moved into the home, they asked for some changes to be made to meet their son's support needs. They said, "They did everything I asked of them". Another relative told us, "It's the best place [name] has been, they seem to be doing good with him".

One of the staff told us they thought working at the home was, "Amazing, a really good experience". Another told us they enjoyed their role, particularly learning new things.

When recruiting the manager told us they are primarily looking for people who care. They recruit a mix of people with experience and some with no experience in care. New staff complete a two week induction, week one is at a head office location and is classroom style, week two is based at Meols Drive Care Home and is more practical. One new staff member we spoke with described the induction as, "Intense, but really useful, it helped me even though I have previous experience".

We saw evidence of these inductions on staff files. New staff also spend two days learning how to support people in challenging situations using a recognised technique (MAPA). Longer standing staff complete one day MAPA refreshers annually. In the first 12 weeks of employment staff are supported to complete the Care Certificate. The manager told us that all support workers are enrolled on a course to achieve a QCF Health and Social Care level 2 or 3 qualification. Some senior staff were working towards QCF Health and Social Care level 5. Staff were supported to complete these qualifications, they were able to use a computer on site to help if needed.

Staff told us they received regular supervision from a senior member of staff. The nursing staff were supervised by the manager who is also a qualified nurse. Support workers were supervised by the deputy manager, a team leader or one of the nursing staff. In people's staff files we saw copies of notes from supervision meetings. On some of the supervision notes we looked at there was further development opportunities identified for staff. We saw notes from annual appraisals that staff had received. Some of these that we looked at supported staff to identify goals they were working towards.

The building was spacious, bright and airy with a large front garden and a rear garden overlooking a golf course. It was decorated to a high standard in a non-clinical way in the style of a period home. Downstairs there were two lounges both with TV's, one with access to the rear garden with a patio area. There was also a dining area in a bright conservatory style room with skylights. There was a reception area with a hallway

and an additional seating area. A managers office, meeting room, nurses station and a clinic room. On the days we visited we observed people using the whole building freely as they chose.

The clinic room was used for the, storage, documentation and administration of medication. We were told it was also used for other reasons such as visiting GP's, District Nurses or Chiropody appointments at the home. The room was well equipped and contained an examination bed. The manager told us this was so that people could have professional medical visits conveniently at the home in privacy, preserving dignity for people.

At the rear of the building there was a three bedroom annex called 'the flat'. This was an self-contained area with a separate kitchen and lounge. From the lounge there was access to the garden. The other nine bedrooms at the home were on the first and second floors of the building. All the bedrooms were well decorated comfortable double rooms with an en-suite accessible wet room. People had been supported to personalise their rooms, we observed people had family pictures and canvas art on their walls along with ornaments and personal keep sakes. There was also a bathroom on each floor with a bath for people to use if it was their preference.

Alongside bedrooms upstairs there was also an office room used by a social worker who works from the home two days each week. A room used by nursing staff during the night to be closer to people who may need support during the night. There was also a fully equipped 'skills kitchen' and an art and craft room containing a computer for people to use.

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 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).

At Meols Drive Care Home three people had a DoLS in place. These people did not have the capacity to consent to the care and treatment they received at the home. There was not a blanket approach to the DoLS, each was individualised, detailed and had been completed after conducting a capacity assessment with each person.

The manager and the staff we spoke with understood the principles of the Mental Capacity Act (2005). The manager had assessed any restrictions that may be in place for people and understood that people can have fluctuating capacity and supported people to make as many decisions for themselves as possible. Staff who we spoke with had an understanding of the Mental Capacity Act and how it promotes people making their own decisions whenever possible and that any restrictions must be documented and in a person's best interests.

People told us they enjoyed the food prepared for them. One person said the, "Food is wonderful, the cook is amazing, like my nan". A second person said the food was "Amazing". Another person told us, "The food is nice, you can ask for something different for tea". The cook showed us around the kitchen. They explained

that they were putting together a Spring / Summer menu and had done questionnaires to gather people's choices and preferences. The cook also went to the 'residents meeting' to find out what food people would like on the Spring/Summer menu. We observed the kitchen environment to be clean and food was stored and cooked safely with the relevant checks documented. The kitchen had scored the maximum five out of a possible five for hygiene from the local authority.

The cook told us they were part of the team and said that food is a big part of people's care and support. They added, "Some people may be having a bad day, it would help to know what they may want, what might help. Food is a big part of life; it's a comfort for some". The cook was able to tell us different people's favourite foods and show us some food they had specifically bought in for people. They also told us that because only a small number of people live at the home they were able to do requests and be creative, on occasion doing build your own burger or pizza. Food is freshly prepared with attention to people having an overall varied and healthy diet. We observed there were crisps, snacks and bottled water available for people to take through the day. We also observed somebody having a toasted sandwich prepared outside of mealtimes at their request. Later on we saw the cook chatting to people living at the home, encouraging feedback and wanting to know if there were any problems; people seemed to enjoy the cook's company.

People's care files contained Health Action Plans outlining how the staff supported people to remain as healthy as possible. There was information about each person's medication, showing what it was for and how it helped. Some people had a health care plan and an epilepsy care plan if needed. People received visits from chiropodists and opticians and if necessary were supported to access health care through their local GP. People were supported to attend a well man clinic every month. The necessary support was offered to people to attend all appointments they may have.

Some people living at the home had epilepsy and had an epilepsy care plan so the staff knew how to support them. Each seizure was documented with a record of what was happening beforehand, details of the seizure and a body map was completed. These had been reviewed monthly or sooner if there was a significant change. The clinical lead for each person did this, this information was shared with the person's GP or relevant medical professional.

Good

Is the service caring?

Our findings

People told us they liked the care they received at the Meols Drive Care Home. One person told us, "I wouldn't like to be anywhere else but this place". They told us how they had received support during a recent difficult time and said, "I needed help to get me through, I wouldn't have coped without their help. All staff here are brilliant".

A person's relative we spoke with told us they thought their son was, "Very happy there". Another relative told us that the home was "Lovely", they added that the staff, "Are caring and look after him properly". A third relative told us they were having difficulties getting to the home to visit as often as they would have liked due to the distance. They told us the manager had arranged for staff to use one of the homes vehicles for the person to visit his family at their home at least monthly. The relative told us this helped and the staff "Always ring when they get back to tell us they are safe".

We asked staff if they would be happy with one of their relatives being cared for at the home. They told us they would be. One staff member commented, "Yes, because the staff here take the time to find out what works for you".

There was a relaxed and homely atmosphere at the home, the culture was not regimented. We observed the staff supporting people in a calm, patient and relaxed way. People were spoken to with respect. We observed one person who had chosen to have a sleep in eating cheese on toast in the lounge looking relaxed and comfortable. The cook told us they will always respond to requests for ad hoc meals saying, "If we can do it, we do it".

Adjustments had been made to the environment taking into account people's needs. For example some people living at the home were sensitive to noise. The self-closing fire doors close to their rooms had been adjusted to a softer close to make less noise. On the top floor of the building a room had been designated as a family room that people could use if they wished to have visits in a more private space.

The manager explained to us that they endeavoured to do everything possible to enable people to become active members of their community. It was a conscious decision to not put a sign on the door of the home or at the front of the building identifying the building as a care home in the neighbourhood. One staff member told us the person they supported had told them, "I want to walk down the street and people know me". They supported this person to be out as much as possible.

People had access to independent advocacy if necessary. We noted that one person had been supported by the staff to access these services when a significant event had happened in their life and decisions needed to be made by the person.

There are times when staff had to physically intervene to keep a person and others safe. The manager told us that they chose the most appropriate techniques and training from their viewpoint to enable staff to do

this with the right approach. Any physical intervention by staff was as a last resort and the team had a strong ethos of any physical intervention being done in a caring way. Staff we spoke with recognised and told us that physical intervention is stressful for both the staff and the people involved. We were told by the manager and different staff we spoke with that any intervention was in the least restrictive manner and for the shortest amount of time. After the intervention the focus was on rebuilding the relationship between the person and staff. Both the person and the staff member are debriefed and if possible debrief each other by talking about what happened and the reasons behind it, to help maintain or if necessary rebuild their relationship.

Staff we spoke with were knowledgeable about different diversion techniques and strategies that worked for people living at the home when a situation looked likely to escalate. Diversion was viewed as the best possible outcome which was always sought. Staff told us in the past things that have worked have been going out for a walk or just getting out, playing a game, chatting, watching a movie or just leaving the room and sitting somewhere else.

People's care plans contained information entitled, 'The best way to present information to me'. It outlined how this can be done in the best way to ensure a person stayed informed. The file also contained a communication passport. One person's passport started by stating, 'I can tell you how I feel, this is how I would tell you'. The files also contained a service user guide which contained information on outside organisations such as the CQC that people may wish to contact.

The manager and staff had developed 'social stories' to help some people who experienced autism to understand different situations. We were told that they were used to encourage a person to understand what a fire alarm was and what they should do if they hear one.

Residents meetings were held where people living at the home could tell the staff their views in a more structured environment. The cook told us they used these meetings to help her prepare the food people liked.

Good

Is the service responsive?

Our findings

One person we spoke with told us "I get out a lot, we all do". They told us they "Enjoyed going" each week to a nightclub. They also "Go to the shops, go out for a coffee or a breakfast. Go to church and then to Wetherspoons after". Other people we spoke with told us what they enjoyed doing. One person was a dog walker, they told us all the different dog's names. They were also a season ticket holder for a local rugby team and went to many of the games, they told us they have, "Got a lot of friends there too". Another person said they, "Like watching TV, watching movies on a computer, I like watching with staff with me". One person told us they had a job in a local café.

One person's relative we spoke with told us, "[Name] has done a lot at Meols Drive, things he never used to do, it's been the best thing for him". Another relative told us, "He goes out a lot, everything is geared towards [name's] needs. I've seen improvements in him during his time at Meols Drive".

One staff member we spoke with told us they, "Like it when people learn new skills, recently a person made their own burgers. It was good to be able to say, 'well done'". The cook told us that one of the people living at the home had a food hygiene qualification and had helped out in the kitchen at times. The manager explained to us their approach to people gaining new experiences. They support people to do what they want to do, sometimes things don't work but he views this as "part of growing". He doesn't say no to people as he feels this is not his role, the manager and his team will advise and then support people to go through the process they have chosen. He told us that "People learn from experiences".

We were told by the manager that people's support times were flexible. On one of our inspection days we noted that the times of staff shifts had been changed to enable a person to go and watch a rugby game. The person had a season ticket and was supported to get to many of the home matches.

The home has an activities co-ordinator who was available between Monday to Thursday who supported people to explore their interests. People living at the home received £30 per week to pay for activities. They could also earn up to an additional £15 per week in 'therapeutic earnings'. These were agreed payments made to people when people took on some personal responsibilities. We were told that there had recently been a coffee morning hosted at the home, the staff had invited the local community policeman, vicar and staff from the local café who know people supported at the home. There was also a social worker who is based at the home two days each week. They help people with any matters that may arise, for example DoLS and financial matters.

Care files we looked at contained personalised information, there was evidence that if possible people and their families had been involved in the planning of their care. Files contained a 'one page profile' highlighting important information about each person supported. This focused on what was important to a person and what people like and admire about a person. The tone of the documents was respectful and positive. What activities people were supported to do was documented along with regular reviews of people's progress.

In the care files people's communication style was documented for the support staff. In the plan it outlined what staff had learnt about people's communication and how to best support people. The document was laid out in a three stage format which was, 1 when this happens, 2 we think it means, 3 we should. There was also verbal and nonverbal clues recorded that indicated how a person was feeling. This information gathered with a person helped the support from staff to be responsive to people needs and wishes.

There were up to date risk assessments for each person in the files. These included how to support people to stay safe and when people may verbally or physically challenge. There was also a risk assessment relating to any occasions when a person may be deprived of their liberty. For specific risks there were risk mitigation plans.

Any incidents that had happened during a person's support were documented. We saw in people's care files that these were reviewed monthly, these reviews involved the person. The notes from these meetings were in the file, there was also easy read copies of the notes for the people supported.

Support planning was aspirational, people's plans contained goals that people had indicated they wanted to work towards, both large and small. There were regular care file audits which ensured that documents were in place, relevant and kept up to date.

People were assessed to determine their level of support. Everybody at the home received one to one support when out in the community; some people received support from two people in the community if necessary.

On the top floor there is a 'skills kitchen' area for more independent people to practice making their own food and further develop their skills. On a notice board there was picture of meals people had recently made. Most people have a 'shop and cook' day when they are supported to plan meals ingredients, shop and then prepare one of their favourite meals. One person told us they were looking forward to making burgers with buns at the time. Another person told us, "I've cooked my own spaghetti bolognaise, I needed some help but staff are always there to help me". The home contributes towards the cost of the ingredients. There are also laundry facilities that people can use if they wish to do their own laundry.

The manager is in the process of recruiting a separate team for 'the flat' offering a different type of support. The environment was smaller and set up so people could be in more control of it, the lounge had their own personal items and ornaments in it, the people living in the flat cooked their own meals with support from staff.

We spoke with one staff member based at 'the flat'. They told us, "The aim is to prepare people for more independent living". Two people volunteered to have this different type of support, the staff were documenting their progress in a recognised way that allowed people to track how they were doing. The staff member told us how these two people are taking increasing amount of control in their lives. A part of the support offered is encouraging people to take control when they have poor mental health. The staff use the 'wellness recovery action plan' (WRAP), for people to recognise what makes them feel good, to explore their feelings, recognising how to keep safe and feel well. The staff also encourage people to use pictorial plans and a wellness toolbox containing items and suggestions of things they can do to enable them to feel better. The staff member told us they "Enjoy seeing people move on, hit their potential in even the smallest way".

We looked at the complaints that had been received from people living at the home. There was evidence that people had been supported to log their complaints with the manager. These had been effectively recorded and the outcome of each complaint was recorded. Most complaints had resulted in the manager meeting with the person and explaining his response to them.

Good

Is the service well-led?

Our findings

One person we spoke with told us they had "Made a few complaints and [Manager] listened to me. A staff member told us about the manager, "If I have any issues, I go straight to him, I'm comfortable with him". Another added his policy is "Very open door", they added that amongst the staff there was "Good teamwork".

The manager in place at the time of our inspection was not registered with the CQC. He had commenced the process and subsequent to our visit submitted his application. It is important that managers apply for registration in a timely manner so that the CQC can ascertain that services are managed by a suitable and competent person.

We looked at the managers records of complaints and found that he had personally taken action on each one and met with the person raising the complaint. Some of them had not been formal complaints as the person may not have had the capacity to complaint in that manner. The records showed that some instances were assessed as complaints by the manager when taking into account the person's actions and how they felt about certain matters. It showed the manager treating people with dignity and respect and tried to really listen to people's views. We observed he had a good, friendly and positive relationships with people living at the home. We often observed him joking with people. On a couple of occasions we observed him offering reassurance and explanations to people, sitting down with them in a calm, supportive, yet frank and realistic manner. He made sure people understood situations by using examples known to the person or making use of social stories. Most of the staff we spoke with and observed had the same approach. The manager told us that everybody living at the home was male and many were younger, this created a lively atmosphere which was mostly positive and people had made friends. However at times people could have disagreements . The manager made sure the support was effective in deescalating this without over responding and ruining the lively atmosphere.

When things had gone wrong in people's support from time to time the manager had shown transparency and had made the relevant referrals to statutory bodies and the CQC.

The manager told us they bought breakfast for the staff on duty each Friday. He thought this gave him and the staff an opportunity to spend some time together, meet in an informal way and it helped to build one team. The manager summed up their role telling us, "I'm here to support the residents and the staff". He added, ""I love it here, I feel quite privileged". They told us that some people had moved into Meols Drive because their previous situation broke down and his approach was guided by, "Believing in giving people second chances and supporting people through difficult times". He worked to ensure that the support provided was 'aspirational' and to enable people to have as close to a regular life as possible. However if they were not able to meet a person's support needs they would work closely with outside partners to help a person to find more appropriate support.

The manager told us he felt well supported by the organisation, he has regular clinical supervision and

managerial supervision and a monthly care governance meeting. It was clear who at the home had responsibility for what, we observed a department lead chart outlining this. It made it clear for staff to know who to highlight concerns to and who was responsible for different aspects of the running of the home. The manager held health and safety management reviews each quarter, we read notes from recent meetings, these outlined actions people were taking from the meeting. The manager sought feedback from people living at the home meeting them individually and all together at residents meetings. The manager also used the information gathered in the audits of the home and incident and accident records to make changes to the support offered to people. They were also used to guide the staff team on how to best support people.

On the ground floor there was a notice board with information for people living at the home in a variety of formats. There was information for all people on how to raise a complaint and their right to complain. There was information on what people living at the home can expect; under the title 'What we expect' and 'What you can expect'. There were recent photos of people doing a variety of things entitled 'Fun at Meols Drive'. There was a copy of the notes from the previous 'residents meeting'. The notes were in a format that would help people find it easier to understand them.