Link-Ability

St Mary's Gate Euxton

Inspection report

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Date of inspection visit:
06 October 2016
07 October 2016

Date of publication:
22 February 2017

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this home on the 6 and 7 of October 2016. The provider was told 24 hours before we visited that we would be inspecting the home. This was so that we could ensure staff and people who lived there would be available during our inspection.

St Mary's Gate is a residential care home supporting four ladies living with complex needs. St Mary's Gate is located in a residential area of Euxton near Chorley. The home is within easy reach of the town centre and transport links can be accessed without restrictions. The home has living accommodation, a large dining area, a domestic kitchen and utility room used as a laundry. The home has four suitably adapted bedrooms and a bathroom. The home is a bungalow so access is only required to the ground floor level.

The home was last inspected in January 2014 under the Care Quality Commission's old methodology. This is the first comprehensive inspection looking at all 16 regulations. The home met the standards of the five regulations inspected in 2014.

At this inspection we found staff approached their job with enthusiasm and optimism. People they supported were treated with kindness and respect. Staff were mostly of a similar age to the current ladies who lived in the home, which allowed for a mutual sharing of age related culture, fashion and interests.

We found the home managed people's medicines safely and undertook risk assessments to ensure people were safe day to day and whilst they undertook the varied activities people were involved with. However, we found that more action was needed to ensure people and staff were safe in the event of an emergency. This included better systems to manage the safe evacuation of the building.

The home assessed people's needs and any associated risks and managed these safely. However we found that assessments and decisions required under the Mental Capacity Act (2005) were not consistently completed.

We had some concerns around the staffing compliment at the home. This was specifically when people were left with just one carer. We did not think the risks of this had been appropriately assessed. Risks included people potentially having to wait to receive care and support which required two staff, risks in the event of an emergency and also risks associated to a situation happening through the night. Incidents could occur through the night which would result in more than one staff member being required. This could include someone form the home having to attend hospital or someone could need additional support. We have recommended the provider completes a thorough risk assessment on the current staffing deployment and ensures these risks are managed appropriately.

Staff were recruited safely to their role and peoples' circumstances were considered when making appointments. The provider took steps to ensure staff were suitable for the role including sourcing appropriate references and checking potential staff criminal histories. However, we have recommended the

provider develops procedures to assess the ongoing suitability of staff. This will help ensure people are always kept safe and supported by suitable staff.

Information was available for staff on how to support people in the home. We found for one person this information was easily accessible and included all assessments and plans to support the individual in one place. For others information was in different places. We acknowledged this was due to the recent implementation of an electronic support planning system; however we have recommended the provider spends some time to ensure the support plans include all the required information about the person to be supported. This would ensure all staff have easy access to the information they need to support people.

People who lived in St Mary's Gate were supported to engage with all aspects of managing their day to day lives, including accompanying staff when completing domestic chores, to shopping for groceries and completing banking tasks. People were also supported to engage with a varied social and leisure calendar. This included usual weekly social events and numerous fun activities including skiing and horse riding.

Staff were caring and respectful. Steps were taken to ensure people's privacy and dignity were maintained at all times. At the time of our inspection the ladies were clean and well presented.

The home and its staff took extra steps and went that extra mile to support people in the home. We found when people had been assessed, as no longer able to participate in daily activities, such as eating and experiencing food, the home worked towards supporting people to participate in these activities. An improved quality of life was high on the home's agenda and with increased support people began to experience food where previously it was thought they could not. One person at the home had been supported to eat and experience certain food textures and tastes and another was about to be assessed to determine if they could begin to taste certain foods.

We also found the home took inclusive steps when engaging in social and leisure activities for the ladies who lived in the home. Certain activities that may be deemed inaccessible to people using wheelchairs were sourced to include people from the home who did use wheelchairs. This included skiing, trampolining and the erection of a garden swing at the home for people to use in their wheelchairs.

The home had very few complaints, but complaints that had been made were managed well and steps were taken to ensure the same issues did not arise. This included a quick response from the provider to the complainant and agreed actions taken. Information was then shared with the staff team to reduce risks going forward.

Family members we spoke with had nothing but praise for the home and its staff. We were told the home had been beneficial to the ladies it supported. We were told how the staff undertook their role with confidence and took time to get to know people they supported. People's likes and dislikes were acknowledged and accounted for, including time taken to plan and prepare holidays for people and with people that were special to them.

The provider, manager and staff monitored the service it delivered and took account of the findings. The home's model was one of service improvement, in order to drive up quality. Quality boards were developed and workshops to drive up quality were undertaken with people who lived in the home, family members and staff. Key areas of importance were discussed including, "We focus support around the individual." And "Support focuses on people being happy and having a good quality of life". We saw from the notes of one of the events that people commented on these themes and improvements were suggested and agreed.

We found the home had a calm and pleasant atmosphere and provided a positive environment to support the ladies who lived there.

You can see what action we told the provider to take at the back of the full version of the report.

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 home had a plan for emergencies, but it needed more work. Actions to reduce the risks of fire needed to be improved.

Staffing levels were calculated based on available funding. The home needed to ensure all the risks associated with lone staff were appropriately assessed and mitigated.

Specific risks to individuals in the home were assessed and plans were put in place to mitigate harm.

The medication management systems in the home were very good and people's medicines were always handled and administered safely.

Is the service effective?

Good

The service was effective.

Where people were provided with their nutrition and hydration via a Percutaneous Endoscopic Gastrostomy (PEG). This is a tube that is inserted directly into the stomach to support people with their nutrition, hydration and medication. This was managed safely. The home took extra steps to ensure people got the best from food and drink, including taste and texture sensation where ever this was assessed as being safe.

People had not always been assessed appropriately under the Mental Capacity Act 2005. Where people required support under this Act it was provided, but we recommended that better recording systems were implemented.

Staff felt supported and training was good. Training was provided specific to the needs of people being supported.

Is the service caring?

Good

The service was caring.

People were not able to directly be involved in developing their

own care, but the home ensured it had all the information to develop and deliver person centred care. Families were very happy with the support provided.

People were treated with dignity and respect and we saw staff adapting support to ensure this was the case.

We saw the home used an object of reference to ascertain preferences from people who lived in the home.

The home took extra steps to ensure the best quality of life for people.

Is the service responsive?

Good

The service was responsive.

Person centred activities and holidays were planned with each individual who lived in the home.

Care was delivered in a person centred way and we saw that staff knew people well.

The home was able to reflect on what worked well and improve specific and focused care for people as a result.

A comprehensive complaints policy and procedure was in place and the home managed complaints in line with procedures.

Is the service well-led?

Requires Improvement

The service was not always well led

Provision at the home was monitored and regular audits took place to drive up improvement.

Aspects of care delivered and the home environment were risk assessed and steps taken to reduce any associated identified risks.

Staff had an available set of policy and procedures to guide their working practice.

St Mary's Gate Euxton

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 the 6 and 7 October 2016.The home manager knew we were coming to the home to complete the inspection. We announced this inspection due to the size of the home to ensure there would be people available on the day we attended. The inspection team included one adult social care inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. A PIR was provided and we reviewed the information as part of our planning for the inspection.

Before our inspection, we reviewed the information we held about the home, requested information from professionals and read information available in the public domain.

During the inspection we spoke with two members of staff, the home manager, the area manager and the chief executive of the provider company.

We reviewed the support plans for all four people who lived in the home and looked at the records held for the management of medications. We looked at communication books and the diary used to support people in the home.

We looked at records around staff recruitment and support, records used to keep people safe and the building audits and monitoring information.

We observed staff administering medication, the interactions between people in the home and the staff supporting them and the mealtime routine.

We also looked around the home including the kitchen and people's adapted bedrooms, the communal areas and garden. We visited the provider office and reviewed the available information used to oversee the management of the home.

Requires Improvement

Is the service safe?

Our findings

We could not speak with people in the home, as no one could verbally communicate with us. We spoke with the parents of some of the ladies and everyone we spoke with was really positive about the service. One parent told us, "I'm really proud of the service it does everything it should and takes good care of [daughter]".

We looked at the information the home held on fire safety, how the equipment was tested and the suitability of procedures to keep people safe in the event of a fire. The home did not have a fire panel. A fire risk assessment had been completed after a situation where the alarm had gone off and the fire department had not been able to indicate where the alarm had been activated. An action from this assessment was that the landlord would install an upgraded detection system, to give better warning in case of a fire. There was one fire alarm testing point within the staff bedroom and a smoke detector in every room.

We saw the fire alarm was tested weekly, but it could not identify if the whole building's system was in order due to there only being one point by which to activate the alarm. The home did not have the fire alarm system checked by external contractors, contractors only tested extinguishers.

A fire risk assessment had been completed by the registered manager of the home and was last reviewed in May 2016. The risk assessment stated that all fire doors in the home were closed. Whilst we saw all fire doors fitted safely into their frame, they were propped open with wedges to allow ease of access with each person in the home being transferable within a wheelchair.

We reviewed the Personal Emergency Evacuation Plans (PEEPs). These plans are used in the event of an emergency, including fire. We noted the plans showed good detail in how to remove people from the home, but each plan highlighted circumstances where two staff would be needed to effectively support people in the event an evacuation. However at times there was only one staff member available.

We found the provider needed to take further action to ensure the people in the home were protected in the event of a fire. We have requested the fire department to visit the home, in order to complete a comprehensive assessment of its safety. We found the current arrangements at the home to be a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a contingency plan in place for use in the event of a major incident. The report was discussed with the manager and we were assured it would be reviewed to better account for the individual concerns at the home.

We noted some risk assessments specifically for moving and handling showed two staff could be required. We were told there were a number of occasions where only one staff member would be available in the home.

We looked at how it was decided how many staff would needed to meet the needs of the ladies. The home

calculated staff numbers based on the financial allowance for each person who lived in the home. The home took great care in ensuring that each person lived an active and complete life, with a number of activities in the community. It was at the times of these activities when there was potential for one person to be left in the home with one member of staff. There was also only one member of staff through the night with all four of the people in the home. We spoke at length with the registered manager and provider about the impact this had on the individuals who lived in the home. Of particular concern to the CQC were situations when people required the support of a hoist from two care workers and also circumstances of providing safe support in the event of an emergency.

We were not assured all the risks associated with support being provided by one carer had been appropriately assessed. Risks also included people potentially having to wait to receive care and support, which required two staff and the risk of someone requiring a person being taken to the hospital during the night.

The provider presented us with updated competency testing for staff to use the hoist, which they were to introduce annually. However, this did not account for situations where current risk assessments showed two staff were or may be required to provide support. We recommend the provider completes a dependency tool to determine safe and appropriate staff deployment in the home and also recommend the provider completes a thorough risk assessment on the current staffing deployment and ensures all risks are managed appropriately.

We reviewed the available records that supported the safe recruitment of staff. We saw that each potential staff member completed an application form, which included all the relevant details including explanations for any gaps in employment. References were obtained and each one we saw was a good reference, highlighting staff were competent for the role they were applying for. Each staff member had an initial DBS (Disclosure and Barring Service) certificate but many of these were over five years old. The provider did not have a current procedure to check ongoing suitability to the role at specific intervals. We recommend the provider ensures procedures are adopted that provide access to ongoing suitability to the staff roles. This will help ensure people are always kept safe and supported by suitable staff.

Staff were competent and confident in fulfilling their role. We were told the rota was always covered and staff all knew the people in the home very well. The atmosphere in the home was calm and cheerful.

We saw that all staff at the home (with the exception of one) had received training in safeguarding in the last two years. Staff were knowledgeable in how to support people safely and understood their responsibilities under safeguarding. We spoke with the management team about safeguarding referrals they had made. We discussed situations where the team may be unsure if the safeguarding referral was needed and we were assured that in these circumstances the provider would phone the safeguarding team to seek clarification. The team were prompted to issue the CQC with a notification of an event that had been investigated appropriately but the CQC had not been informed about. This was done on the day of the inspection and we were assured the provider understood their responsibilities going forward.

The home tested equipment and utilities in the home to ensure they remained safe to use. We saw the professional testing of equipment including the gas and electrical installations. However, there was one hoist used by people in the home which had not been tested for over 12 months. We discussed this with the manager who told us the hoist were personally owned by the person who used them. We were assured the provider would ensure the equipment was tested without delay. The portable electrical equipment had recently been tested and we saw that one lamp had failed the test. The plug had been removed from the lamp to ensure it could not be used.

We saw the home completed a number of risk assessments to support people in the home. These included assessments for daily living and other circumstances, including holidays and activities in the community. We saw these were comprehensive, were read and signed by all staff to show they understood and could follow them.

We looked at the records the home held for accidents and incidents and found good records were kept and the assistant director reviewed these as they were submitted. Each accident and incident was investigated and lessons were shared in staff meetings. Any concerns, where appropriate were shared with family members during the regular link up meetings that were held.

We observed staff administering and preparing medicines. The system used was suitable for the people being supported and had safeguards built in to reduce the risk of errors. Medicines management and audits were completed and understood by all staff. Staff had their competency tested in this area.

Records used to monitor medicines were checked daily by staff at handover, monitored by the home manager weekly and also intermittently and quarterly. Where concerns were noted positive action was taken to ensure risks were reduced. This included the recent introduction of trays with people's pictures on, upon which to prepare that person's medicines.

There were comprehensive procedures in place for when people went out to ensure no medicines were missed and any medicines removed from the home were accounted for and managed safely. There were good support plans in place for each person in respect of their medicines and protocols were in place to manage 'as and when required' medicines, including specific details of each person's triggers and responses to pain. These were an excellent indicator to support staff when to administer as required medicines to ensure people were kept comfortable and pain free.

There were good policies in place for the receiving, recording, storage and return of medicines and we saw these were followed. Medicine Administration Records (MARs) included good detail about people and their medicines and included a picture and clear person centred guidance on how they should be administered. There were also records of any allergies or any known difficulties in medicines management. We also saw a high level support plan for each person for new staff to get familiar with each person's medication regime. Staff told us they were never left to administer medicines until they were completely confident to do so.

Each person's medication support plan was read and signed by staff to say they had understood it and there was a signatories list within the medication management paperwork. We saw some occasions where medicines had been hand written on the MARs and were only signed in by one person. The reason for this was explained as at times only one staff member was available. The home had a system when this was the case when medicines were checked out for activities. We were assured this would be extended to cover the recording of handwritten short term or mid cycle medicines accepted by the home.

The home had appropriate procedures in place to ensure the environment was kept clean and there was a good stock of Personal Protective Equipment (PPE) for staff to use when delivering personal care. We had no concerns about the environment or infection prevention and control.

Good

Is the service effective?

Our findings

We spoke with a family member about the staff and how they thought they met the needs of their loved one. We were told, "I know all the staff very well and they are all very good." We were told they looked after their family member well and all their needs were met. We were also told the staff knew their daughter very well.

People who lived in St Mary's Gate had limited capacity and each lady was living with complex needs, including some limitations with their mobility. Each person was predominantly supported with their mobility by a special adaptive and personalised wheelchair. People could not leave the home unattended and relied on staff for support in all aspects of daily living, including meeting their social and emotional needs.

People who lived in the home had been in receipt of support from services most of their lives and as such had transitioned from child to adult services. Family were heavily involved with each person who lived in the home and were involved with developing and agreeing to the care and support provided.

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.

The provider had applied for DoLS authorisations for each person who lived in the home. We reviewed the available assessments to support the applications. It was clear staff had recently gained a much better understanding of the requirements under the MCA. The most recent admission to the home had capacity assessments completed for each restrictive practice used, in order to keep them safe from harm. These included bedrails, the use of a harness on the wheelchair and within the shower and always leaving the home with staff.

Decision specific assessments had been completed including the appropriate best interest decision. Best interest meetings had included appropriate professionals and family members and had involved the individual preferences, as much as practically and safely possible to do so.

This person's plan of support was clearly developed within the principles of the MCA and we could see assessments and decisions had been made to ensure the person was kept safe, whilst ensuring practices

were as least restrictive as possible.

The other three support plans did not include the same detail. We could see that DoLS applications had been made, but when the information to support this was not available, there was potential the applications would not be granted.

We recommend the provider reviews the available assessments under the MCA and assures everyone is protected by the completion and implementation of assessments and appropriate best interest decisions.

Staff we spoke with told us they were well supported and well trained to complete their role. We reviewed records on training and induction for staff and looked at supervisions and appraisals. Staff were also supported with regular team meetings. Each record we reviewed showed the people in the home were at the heart of discussions. Team meetings focused on peoples' needs and what was going on in their lives. One to one staff supervision focused on how individual staff could best support people in the home and annual appraisals identified any additional support staff might need to best meet the needs of people in the home.

We saw support plans, policies and procedures and risk assessments were all shared with staff and staff signed to say they understood them and could follow them. We also saw that the competency of staff was tested to ensure they were following the guidelines and plans. The registered manager of the home often worked at the home, so was very much part of the team. Staff were comfortable around management and we could see there was an open and honest dialogue between staff, their peers and manager.

Everyone who lived in the home was supported with the use of a Percutaneous Endoscopic Gastrostomy (PEG). This is a tube that is inserted directly into the stomach to support people with their nutrition, hydration and medication. Two of the people in the home received their nutrition and hydration via a PEG. Two others received their medication via the PEG but were able to eat a specific assessed diet.

We reviewed the information to support people with their hydration and nutrition. Support plans were specific to the needs of the person and included the use of the PEG in varying degrees. One person at the home had successfully been supported to eat some simple foods and another was awaiting an assessment from the Speech and language Team (SALT) to ascertain if they could progress to tasting certain foods and experience certain textures in their mouth without increasing a risk of choking.

The home worked well with external professionals when supporting people with their diet and we saw specific plans to show how people were supported. This included where people had lost weight. The home worked with the dietician to support them to gain weight. Recent records showed this was the case.

Risk assessments were developed to support people when they were receiving tastes or types of food to reduce the risks of choking.

The staff at the home worked with a number of professional teams including the district nurse team, local podiatry teams, dietician and SALT. We also saw how the home worked with consultants supporting people with more complex needs. People in the home had specific monitoring tools completed every day. These were then taken to each specific appointment with the consultant to allow the consultants to deliver and maintain a quality of life for people.

The home had systems in place to ensure people were monitored in line with their needs. We found the home made appropriate referrals to external professional support services as and when required.

Good

Is the service caring?

Our findings

Those who lived in St Mary's Gate could not communicate verbally. One family member told us, "The staff know her inside and out and can support [daughter] with ease." We asked what was meant by this and were told, "[Daughter] has looks that depict her mood, and the staff know all of them." When we asked what the family thought of the care and support provided to their families' one person told us, "I am so happy to have found somewhere where [daughter] can live her life to the full." They went on to say, "I've found somewhere that looks after [daughter] as good as I would. That means so much."

Staff at the home clearly enjoyed their job. Interactions between staff and people in the home were meaningful and included staff taking people around the home as it was cleaned, as food was prepared and as laundry was undertaken. This showed awareness by staff of ensuring people in the home were interacting with their immediate surroundings providing a sense of home and belonging. Families told us staff at the home ensured their families experienced life rather than just live it. This included simple things like going on a bus, rather than in the car to places and ensuring people who lived at the home were with staff when their shopping was bought or their banking was done.

As people joined the home there was clear and practical evidence to show staff and the home worked hard to support people to gain and keep their autonomy as much as possible. This was noted through two people who were wholly and effectively supported with their nutrition and hydration via a Percutaneous Endoscopic Gastrostomy (PEG). The tube directly into people's stomachs passed adequate nutrition and hydration to support people. People were healthy and there was not a practical reason to change this. However, the home wanted people to experience food as much as possible. With appropriate professional support and encouragement and patience from the staff at the home, one person was now enjoying some foods and another was hoping to be able to begin to taste some foods following professional support and assessment.

People at the home were supported to remain part of their families' lives. Staff took note and recorded specific important family events, including birthdays and anniversaries. Staff took people from the home to the shops and purchased gifts from them for their family members at these special times. This allowed people in the home to feel unexpected appreciation from those that loved them. One father told us, it was his other child's birthday recently. They returned from work to find their daughter there with a carer from the home to wish his son a happy birthday. He went on to say, "No one asks staff to do this and it's these extra things that make the home the right choice."

The people in the home had been faced with recent exclusion from local colleges and training centres. Thresholds for programmes had heightened and people who lived in St Mary's Gate had been assessed as having too complex needs to benefit from certain courses and programmes. Staff at the home did not accept this and therefore accessed course work for certain programmes and developed person centred classes within the home. This had included art and some sports programmes. One example was the home hiring 'Wheels for All'. The programme included a specially adapted bike, which was attached to the person's wheelchair and staff pedalled the bike to give people the sense of freedom associated with riding

the bike themselves.

The home had also recently purchased a wheelchair swing which we saw being set up in the garden on the day of the inspection. The garden had raised flower beds to allow people to engage in gardening activities.

Support plans were extremely person centred and addressed many other areas other than basic care needs. One support plan identified why people may be awake at night and gave staff tools to help settle and support people.

As people in the home could not verbally communicate they were not able to give their verbal consent. Most may have also lacked the capacity to always consent to support. Staff had developed the 'object of reference' tools to allow people in the home to show approval or not, to interventions and support provided. This was also used to reduce anxiety in the support provided. By showing an object of reference, for example a toothbrush prior to supporting someone to brush their teeth, allowed the people being supported the opportunity to show approval or not. Staff could then proceed to support the person with brushing their teeth or not.
Families of people who lived in the home told us they felt involved with the care and support their loved ones received. We were told they were welcome at the home at any time and had regular formal meetings with their family member's key worker.

The home had recently completed an event to identify what was important to people in the home. The event was set as a craft event and it was tactile and interactive, so people in the home could be included. Family members were invited and when we spoke with them, they praised the home for the event and how it showed the home cared about the life of the people who lived in the home.

Every interaction we saw in the home was undertaken with dignity and respect. Staff worked hard to deliver the support people needed, whilst respecting the wishes of those they were supporting. We saw specific training dedicated to the individual needs of people in the home, including the objects of reference training. We also saw training had been delivered to develop better quality of life including, basic foot care, sing-along and ASD (Autistic Spectrum Disorder) awareness.

People who lived in the home were clean and well presented. People's hair was styled and clothes people wore showed a sense of individuality and preference.

Good

Is the service responsive?

Our findings

Families told us they were impressed by the activities provided to their family members. One told us, "[Daughter] has a better social life than me." Another said, "Time was spent going through what [daughter] liked to do and she does one of those things every day."

We reviewed all four people's support plans on the electronic system. We found one of the plans to be completed well and all sections of the plan to be updated regularly and in line with the regulations. Whilst we saw everyone's plans were regularly reviewed and always reviewed at point of change, we found the information in all but one was not as comprehensive and some plans missed key elements. For example, plans for people that had been in the home longer did not hold all the assessments for decisions made under the Mental Capacity Act. Some did not include the updated information that was held with the medicines file.

The information was available within the home on how to best support each person living there. For some, the information was easily accessible and all relevant and up to date. For others information was in different places. All staff knew each person well and we acknowledged gaps in information was due to the recent implementation of an electronic support planning system. However, we recommend the provider spends some time to ensure all the support plans for all people in the home include all the required information about the person to be supported. This would ensure all staff have the information they need to support people.

Staff sought out services that provided fun activities usually thought of for only fully mobile people. Specialist services that provided numerous activities including, ice skating, horse riding, skiing and trampolining for people restricted to wheelchairs or those who required hoisting equipment to keep them upright. Pictures of these activities clearly showed the ladies thoroughly enjoyed them.

We saw assessments completed with families and professionals that looked at individual's perspectives and needs including holidays and time spent with other people outside of the home.

The home had comprehensive documents which highlighted all the equipment and individual support aids required for people in the home. The equipment was checked daily and stock was always available including a number of spares.

People in the home were always well presented. One family member told us, "[daughter] always smells lovely and her hair is always immaculate and nicely styled."

Everyone at the service had their own vehicle specially adapted to their needs. The home tried to ensure there was always an available driver for each person.

We reviewed the home's procedures for ensuring the needs of the ladies who lived at St Mary's Gate were met in day to day practice. We saw a communication book and diary were used daily and all staff recorded

the events of the day. This included any booked appointments, visitors, phone calls made and received. The book was also used to highlight any issues that staff or the manager wanted to discuss or any issues that needed to be followed up. On the day of the inspection the manager had returned to work following a short break. We saw them review the detail of the communication book and make notes as to any actions or follow up work they wanted to complete.

We noted a number of different scenarios from the book including support needs for people in the home, appointments to be made and one item of household equipment that needed to be repaired. We tracked each scenario through the records of the home and could easily ascertain the details and completion of all scenarios except one. The manager told us where we could find the information for one scenario and confirmed the issue had been resolved.

Each person at the home had a Health Action Plan and communication passport which was held at the home but was also always available when the individual went out into the community. This key information would enable other professionals to have all the information they needed to be able to meet the needs of the individual in the event other services were required. This included details of hospital admissions and medication, how the individual displayed pain and details of their current medical conditions.

We reviewed the electronic and paper records used to identify how the home were supporting people. We saw there were mostly electronic records for the support plans and assessments of people's needs. We saw one person had an iPad and their support plan and records were accessible to them through their iPad. We also saw staff could access records through a computer in the home.

Support plans were developed with the family and where relevant the social worker or other professionals involved in people's support. Plans were comprehensive and person centred in their approach to delivering services. Plans looked not only at daily living needs, but also at the care and support needed to experience life. Topics covered included relationships, leisure, cultural and spiritual needs, emotions and decisions. All support areas were linked to outcomes, such as I want to enjoy new activities. Routines and social habits were built into outcomes to ensure people got the best from any support provided.

Each person had a communication plan which identified how and why people in the home could or would react to certain situations. The plans included prompts and signs of emotive states, such as happiness and anger. Plans included likes and dislikes and identified the person's favourite objects linked to the objects of reference framework for communication.

The home had a service user guide, which was also available in an easy read format. The complaints procedure was available in this guide. The home had received only three complaints in the last five years. There was a verbal complaint made in March 2016, which we followed through the procedure. The complaint was dealt with within a week and included a written response and a face to face meeting. The issue was discussed at director level and a director attended the next staff meeting to discuss the issue and the actions agreed to ensure the issue was resolved and did not happen again.

Requires Improvement

Is the service well-led?

Our findings

When we spoke with families about the home and the support the staff at the home provided for the people who lived there, responses were very positive. We were told the service provided was fantastic and second to none. Families told us they were proud of the staff and that they always worked well, even in difficult circumstances. One family member told us of a recent sickness outbreak amongst the staff team and how professionally the staff and home managed it. We were told how none of the ladies in the home were poorly because of how well it was managed. Staff stayed away as they needed to ensure people in the home didn't get ill and other staff covered for people to ensure there remained a consistent team in place.

All the families we spoke with were heavily involved with the care of their daughters. Each family spoke of their expectations on the service to look after their loved one. Each told us of the high standards they expect and how the home had met them. One person told us, "We struggled with placing our daughter anywhere as we really wanted her home with us. Since [daughter] has been at St Mary's Gate we now know, it would have been the wrong thing to do, to not allow her to live there." Another told us, "We couldn't have provided [daughter] with the level of support and access to activities and social life, that the home has."

The home has a registered manager who has been registered with the Care Quality Commission for nearly five years. The manager was previously registered with the Commission for Social Care Inspection. The manager is at the service approximately four days a week and has an office base in the provider offices approximately three miles from the home. Staff at the home felt supported by the manager and families we spoke with were happy with how the home was managed.

The home had not received a comprehensive inspection previously and under the old methodology was compliant with all the regulations inspected. Many of the regulations inspected under the comprehensive methodology had not been inspected previously.

The home had a consistent staff team at the time of the inspection and the home manager, staff and families acknowledged the importance of a consistent team when working with people with complex needs. Everyone we spoke with shared a mutual respect of each other and of the service provided to the ladies who lived in the home.

The home had procedures developed specifically for St Mary's Gate and the environment within which the ladies lived. Those that required further development were given immediate attention following the inspection. Families told us of the provider and home's commitment to driving up standards and we were told and saw evidence of quality events. Families were regularly asked for feedback and were instrumental in how the home moved forward. Quality forums at board level were fed into by sub groups and forums that included people who lived in the home, staff and families. Minutes of these meetings were available in an easy read format to ensure everyone had an opportunity to understand them.

People's key workers met regularly with families in link up meetings. This was an opportunity for people to discuss, what was going on in people's lives, any issues or concerns and how these could be resolved. The

meetings also discussed anything additional families would like to see in the home or in particular to their daughter's care.

Regular team meetings ensured the information from quality groups, link up meetings or other family engagement meetings was shared with the team and embedded into the culture of the staff working in the home. We saw suggestions made by families were shared with staff and then these were monitored. For example, one family wanted a diary to be kept for their daughter, so they could see what they were doing and how they had been on a daily basis. This was shared at handover with all staff and was started. Then at the team meeting it was discussed and reinforced so it was continued and the importance of it to the family was understood by all staff.

We also saw regular tenants meetings, which shared information important to people using the services from linkability. Items discussed included new community schemes, travel assistance and personal safety. Again the minutes of these meetings were provided in an easy read format.

The provider and home also had a comprehensive system for quality monitoring and auditing. We saw details of daily, weekly and monthly checks undertaken within the home and less frequently audits and checks completed by management and the directors of the provider. This included daily medication checks, weekly vehicle checks and monthly health and safety audits of the home. We saw risk assessments were completed and reviewed annually. However as can be seen throughout this report the audits and monitoring in place had not always identified the need for improvements. We recommend the provider and home manager ensure the available audits are used to identify the requirements of the Health and Social Care Act (Regulated Activities) Regulations 2014. This would help the provider ensure the required standards were met.

The manager of the home completed a monthly manager's check which included a review of support plan information, accidents and incidents and complaints. Senior management completed six monthly quality cheeks at the home. These checks included ensuring all staff had access to the required training and were in receipt of the available support through supervision and appraisal. Health and safety checks on the premises included a review on maintenance and decoration in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Emergency planning required more thought. Risks associated with fire needed to be more robustly risk assessed and improvements required by the fire department needed to be implemented.