Care Matters (S.E.) Limited

Abbey Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 15 and 16 August 2016 and was unannounced. This service provides care and accommodation for up to five people with physical and mental health needs. Five people lived at the service at the time of our inspection.

The provider had submitted a change to their statement of purpose to include providing support to younger adults with mental health needs. As part of the inspection we reviewed whether they were able to meet the needs of younger people. We found the provider was able to meet the health and social care needs of this group of people.

There was a registered manager in post. A registered manager is a person who has registered with the CQC 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.

At the last inspection undertaken on the 25 March 2015, we asked the provider to make improvements in relation to a number of areas.

The provider had not ensured that care and treatment was always provided safely. Risk assessments, fire safety procedures, staffing levels, recruitment processes and PRN medicines protocols were not sufficiently robust to keep people safe. In addition, the policies and procedures for safeguarding and whistleblowing required updating.

Staff training, supervision and inductions to support staff performance and development required improvements. There was no system in place to monitor that people' diets were nutritious and well balanced.

The provider had not ensured people had a structured activity programme based on their individual likes and dislikes.

Systems were not in place to monitor or analyse the quality of care provided. The provider had no system to demonstrate how they had assessed, evaluated and improved the quality of care provided. Management and staff meetings were held however there were no records of the discussions held. Action points had not been recorded or measures taken to demonstrate service improvements were made as required.

The provider sent us an action plan stating they would have addressed all of these concerns by 28 August 2015. At this inspection we found the provider was meeting these regulations and had acted upon the recommendations made.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk

assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to keep people safe. Thorough recruitment procedures were in place which included the checking of references and personal identification.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines to include 'as required' medicines and kept relevant records that were accurate.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered. Staff sought and obtained people's consent before they helped them. Staff training in the Mental Capacity Act 2005 (MCA) and DoLS was effective. People's mental capacity was appropriately assessed about particular decisions. When necessary, appropriate meetings were held to make decisions in people's best interests, as per the requirements of the MCA. Bed rail assessments were not in place for people where needed and their consent had not been obtained. The registered manager addressed this after the inspection and sent us records to evidence this.

Staff received one to one supervision sessions and all essential training for their role. Staff said they could benefit from more frequent supervision in some cases. We have made a recommendation about this.

The staff supported people to have meals that were in sufficient quantity and met people's needs and choices. Staff knew about and provided for people's dietary preferences and restrictions.

Information was provided using accessible language and pictures about menus, activities and how to complain, to help people understand this information.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect.

People were promptly referred to health care professionals when needed.

Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. People's individual assessments and care plans were reviewed monthly or when their needs changed. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People were involved in the planning of activities and an individualised activities programme was in place which met people's preferences. People's feedback was actively sought and action taken to meet their needs. Some people wanted to go out more and on some shifts staff were not consistently available to support them to meet this need. The registered manager told us they would provide additional staff for those shifts immediately and would deploy an additional member of staff to meet this need.

Staff told us they felt supported by the registered manager and they had confidence in their leadership. The registered manager was open and transparent in their approach. They placed emphasis and priority on the person centred needs of people at the service.

There was a system of monitoring checks and audits to identify any improvements that needed to be made. The management team acted on the results of these checks to improve the quality of the service and care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Requires Improvement

The service was effective.

Staff understood the principles of the Mental Capacity Act 2005 and about the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted appropriate applications in regard to the DoLS and had considered the least restrictive options to keep those people safe. The provider had not sought people's consent to bed rails which is a potential restriction. They addressed this after the inspection.

The staff supported people to have meals that were in sufficient quantity and met people's needs and choices. Staff knew about and provided for people's dietary preferences and restrictions.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was responsive to people's individual needs.

The delivery of care was in line with people's care plans and risk assessments.

People had an activities programme in place. Some people wanted to go out more and the registered manager assured us they would take immediate action to respond to their request.

People were involved in the review of their care plans. People's care was personalised to reflect their wishes and what was important to them.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Good

The service was well-led.

The registered manager welcomed people and staff's suggestions for improvement and acted on these. Staff had confidence in the registered manager's style of leadership.

There were audit systems in place to ensure that essential standards of care were met.

The registered manager placed emphasis and priority on meeting people's needs in a person centred way. There was an open and positive culture which focussed on people.

Abbey Lodge

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 carried out 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 was carried out on 15 and 16 August 2016 and was unannounced. The inspection team consisted of one inspector and an inspection manager.

The registered manager had sent us a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before our inspection we looked at records that were sent to us by the registered manager or the local authority to inform us of significant changes and events. We reviewed statutory notifications. These are information about important events which the provider is required to send us by law. We reviewed our previous inspection reports.

We looked at records which included those related to people's care and medicines. We looked at three people's assessments of need and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and four staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with three people who lived at the service to gather their feedback. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager and two care staff members. During the inspection we spoke with two professionals with direct knowledge of the service. At the last inspection on 31 March and 01 April 2015 we found improvements were required at the service. At this inspection we checked to see whether the provider had made the required improvements and completed a comprehensive inspection of the service.

Good

Is the service safe?

Our findings

People were supported to keep safe at the home. We observed staff prompting someone who was eating a snack very fast. Staff prompted them discreetly to slow down their eating to reduce the risk of choking to keep them safe. Staff supervised them at mealtimes and when eating to ensure they paced their eating and drinking. The person had a laminated prompt sheet with pictures and easy read language to help them understand and remind them to eat slowly. One visiting health care professional told us, "Staff are open to suggestions with X. [Due to risk] staff do observations and ensure that X is safe and the environment is safe. They work closely with [health care professionals]. There is close liaison and direction."

At the last inspection undertaken on the 25 March 2015, the provider had not consistently ensured that care and treatment was always provided safely. Risk assessments had not always been carried out to determine the actions required by staff to keep people safe. There were no formal systems to evaluate the care provided and to make improvements.

At this inspection improvements had been made to ensure risk assessments detailed the actions required by staff to keep people safe. Risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people's needs changed. Risk assessments included measures to reduce the risk of skin breakdown, behaviours which may challenge, changes in people's mental health needs, catheter care, falls, and nutritional risks to include choking. Measures in place, to reduce the risks of skin breakdown included provision of equipment such as air mattresses for people's beds, moulded seats for wheelchairs with pressure relieving cushions and regular pressure relief to include regular turns whilst people were in bed, Staff completed routine observations of people's skin condition. Staff were aware of people's risk assessments. One staff member talked about how they managed safe catheter care. They said, "I make sure I wash my hands and use protective equipment. I drain the catheter and check people's skin around the catheter site and make sure it is kept clean. I make sure the catheter is changed regularly."

Risk assessments were in place where people and others were at risk from behaviours which may challenge. Detailed behaviour plans were in place which identified potential triggers to people's behaviours and how staff should support people safely when they occurred. These were regularly reviewed to ensure they were suitable for people's individual needs. Where people were regularly observed due to identified mental health risks, records were kept to demonstrate this was taking place. One staff member told us how they regularly checked people rooms to ensure they were free from potential hazards that could cause people harm. Staff were able to talk to us about people's identified risks and how they supported people to keep safe.

At the last inspection on 31 March and 01 April 2015, Records of incidents of behaviours that challenged did not always provide sufficient information to support risk assessment reviews to keep people safe.

At this inspection the provider had made improvements to the system for recording and analysing accidents and incidents. Incidents were monitored to identify any areas of concern and any steps that could be taken to prevent incidents and accidents from recurring. Appropriate logs were completed, analysed and audited

by the registered manager to identify any trends or patterns. Staff completed incident forms, reviewed and updated the person's risk assessment to ensure that this risk was made known to staff and documented the best way of dealing with this situation. This information supported the development of behavioural risk assessments, staff understanding and response to behaviours and helped to ensure that people were safely and consistently supported.

At the last inspection undertaken on the 25 March 2015, fire drills had not been held and personal evacuation plans had not been carried out to determine the actions to be taken in the event of a fire.

At this inspection, fire safety procedures had been improved to ensure people would be safe in the event of a fire. The provider had a robust fire procedure in place. People had an individual Personal Emergency Evacuation Plan (PEEP) in place. PEEPs identify people's individual independence levels and provide staff with guidance about how to support people to safely evacuate the premises. PEEPs recorded support and equipment people would need in the event of fire evacuation. Fire protocols were in place which recorded how people would respond or how staff would ensure their safety in the event of a fire. A recent fire drill had identified the need for additional staff training in supporting people who used hoists to safely evacuate. Additional training was provided and staff told us they were confident in managing in the event of fire to keep people safe.

At the last inspection undertaken on the 25 March 2015, the policies and procedures for safeguarding and whistleblowing required updating.

At this inspection, staff understood the procedures for reporting any safeguarding concerns. All of the staff we spoke with were able to identify different types of abuse and were clear about their responsibility to report suspected abuse. They were aware of the whistleblowing procedure in the service and expressed confidence that any concerns would be followed up. Staff were up to date in their training in the safeguarding of vulnerable adults. The registered manager had a safeguarding policy in place that reflected changes in relevant legislation. The registered manager discussed safeguarding matters and other key training areas in staff meetings and used real life examples to support staff knowledge in this area.

At the last inspection undertaken on the 25 March 2015, staffing levels were generally sufficient to meet people's needs however, there were times when staff levels left people at risk.

At this inspection, there was a sufficient number of staff to meet people's needs in a safe way. We looked at staffing rotas that indicated that enough care staff were deployed during the day, at night time and at weekends to keep people safe. The registered manager reviewed staffing levels regularly, took into account people's needs and staff skill mix to ensure a sufficient number of staff was deployed. Additional staff were deployed when necessary, for example; when people needed one to one support when they were unwell and needed to attend health appointments. The registered manager told us they had two vacancies which they were actively recruiting to. Bank staff helped out on some shifts and staff did additional hours where needed. Agency staff with knowledge of the service worked some weekend shifts. People's requests for help were responded to without delay. One visiting health care professional told us, "There are enough staff on duty. Staff do a lot of one to one work with people. The staffing levels are definitely safe. Staff are always aware of where people are. There is a good staff ratio." There was an on-call rota so that staff could call the designated manager out of hours to discuss any issues arising.

At the last inspection on 25 March 2015, there were no protocols in place for the use of medicines prescribed on an 'as required' basis.

At this inspection, improvements had been made to medicines management. People's medicines were stored, managed and administered safely. The medicines administration records (MARs) were detailed and accurately completed. We observed medicines being administered safely to people. Staff introduced themselves to the person, explained what they needed to do. Staff gave people time and support to take their medicines without rushing. Sometimes people wanted to discuss and have explanations about the medicines they were taking. The registered manager told us that they and staff explained to people how the medicines helped them. This information was not recorded to demonstrate how people were supported to better understand their needs. The registered manager acknowledged this and told us they would record this information in future.

People's PRN or 'as required' medicines were clearly detailed in their care plans. Information was recorded about people's individual PRN dose and recommended times for administration. Staff were provided with guidelines as to when they should consider use of PRN medicines, to include where people may have behaviours which challenged. MAR instructions clearly detailed how staff should administered PRN medicines. Staff told us how they explored with people whether they needed PRN. For example they told us, "With X, I talk with them first, check pain levels, try and distract them and give pain relief PRN if required." Staff discussed use of PRN medicines for people at every staff shift handover meeting to ensure staff had up-to-date information about people's needs

The provider had a protocol in place should a medicines error occur. No medicines errors had been recorded at the service. The registered manager told us they would act promptly and appropriately to reduce risks to the person. They would obtain medical advice and monitor the person to ensure they remained safe and well. They would ensure staff received refresher training in medicines management before resuming this role.

At the last inspection undertaken on the 25 March 2015, recruitment procedures were not consistently robust.

At this inspection, safe recruitment procedures were followed to ensure staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and references had been taken up before staff were appointed and references were obtained from the most recent employer where possible. Disciplinary procedures were followed and action was taken appropriately by the provider when any staff behaved outside their code of conduct.

The provider had a rolling reschedule in place for the refurbishment of the home. Some areas of the home had been subject to wear and tear to include communal walls, doorframes and skirting boards. The registered manager was aware of this. They told us the next phase of refurbishment was due to take place in the next month.

The provider had put in place a maintenance system to ensure repair work was prioritised and dealt with. For example a boiler had been replaced; a door frame and toilet seat had recently broken and had been repaired. Each person's room had been assessed for possible hazards. The premises were well maintained and systems were in place to ensure the service was secure. There was a system in place to identify and log any repairs needed and action was taken to complete these in a reasonable timescale. We identified one repair which had not been identified, which was a hole in the bath panel. The registered manager recorded this to ensure the required repairs were completed.

The home's equipment was regularly checked and serviced. Safety checks had been carried out throughout the home and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They addressed the environment, water temperature, appliances and fire protection equipment. Portable electrical appliances were checked regularly to ensure they were safe to use.

The home environment had been adapted to meet people's individual needs. Staff completed a monthly 'room risk assessment' to ensure the environment was safe for people to use. Rooms were minimalist and free from clutter, to reduce the risk of hazards and to reduce the risk of injury in the event of potential incidents of behaviour which challenge. Walls contained information to support people with dementia. Words such as 'to the garden' and 'to the living room and assistance' were painted on the walls in large print. This helped people find different rooms where they may be experiencing some confusion. There was a wet room on one level and bathing equipment with Jacuzzi bath available to support people to take a bath or shower according to their preferences and mobility needs. Written comments from a visitor read, 'A lovely open plan house which is brilliant for people with mobility issues.'

There was a business contingency plan in place that addressed possible emergencies such as extreme weather, infectious diseases, damage to the premises, loss of utilities and computerised data. Procedures were in place to ensure continuity of the service in the event of adverse incidents.

Requires Improvement

Is the service effective?

Our findings

People were happy with the care and support provided by staff. People told us, "Staff are brilliant. Four different staff work with me. They all muck in together" and "The staff are fine." Written comments from relatives and visitors read, 'Beautiful home, very friendly and calm. Lovely staff who are very helpful.' One health care professional wrote, 'Staff are helpful, open and knowledgeable regarding clients. They will contact me if and when there is a problem or concern.'

At the last inspection undertaken on the 25 March 2015, improvements were required in relation to staff support and development needs. Staff did not have opportunities to attend specialist training to meet the individual needs of people at the service.

At this inspection, people were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Training provided included health and safety, first aid, dementia care, manual handling, safeguarding and infection control. Training records were up-to-date. The provider had monitored staff training needs and scheduled training courses for staff. Additional training included mental health awareness, managing challenging behaviour, food and nutrition and dementia care. One staff member was completing a 12 week distance learning course in mental health awareness. Since the last inspection training had been set up to ensure that staff had access to all the training they needed to meet the needs of their role.

Staff had their competence assessed in practice. For example, the registered manager completed medicines competence assessments to develop staff skills to give people their medicines effectively. One staff member told us how they supported someone to positively manage behaviours which may challenge. They told us, "If X gets bored then we may see challenging behaviour." They told us about other triggers to their behaviour. They said, "I try and reassure X and try to keep them engaged with things they are interested in. They tend to calm down quickly and like to go to their room. I have had training in mental health needs."

Training was tailored to the health and support needs of people at the service. Staff received formal annual appraisals of their performance and career development. Some staff said they would like more practically based training. They told us they found practical training sessions a more suitable training method for them. Some staff said they would like additional in-depth training in medicines management with particular emphasis on gaining knowledge of different medicines and the potential side effects. The registered manager was responsive to this feedback. They told us they would review and develop training approaches and systems to meet staff individual needs.

We recommend the provider further develops staff training needs and preferred learning styles to tailor training to staff individual needs.

At the last inspection on 25 March 2015, staff had limited opportunities to attend formal supervision meetings. Staff had not had the opportunity to attend supervision meetings in line with the provider's policy.

At this inspection, care staff received one to one supervision sessions and completed an annual appraisal of their performance. An appraisal was outstanding for one staff member at the time of our inspection. The provider's appraisal policy stated that 'all staff will have a yearly appraisal and this will be reviewed at 6 months.' One member of staff who had been at the home for over a year had an appraisal recorded in her file January 2016; another staff member did not. Supervision covered matters relating to people's needs, the team, training and development. The registered manager followed through on actions staff raised with them. Staff had supervision sessions to develop their performance. The registered manager said they routinely asked staff whether they required additional supervision sessions. However, some staff said they would like to have supervision more frequently. They told us they would review this with all staff to ensure their support needs were fully met. The registered manager said that the aim was to do supervision every six weeks; however records did not indicate this was happening in all cases. The provider's written policy stated that staff should have 'appropriate levels of supervision that depends on their qualifications, experience and own identified needs' This did not set out a specific timescale for this.

We recommend the provider reviews the supervision policy to ensure staff individual support needs are fully met.

At the last inspection staff on 25 March 2015, there was no system in place to check that staff had understood the content of the induction process.

At this inspection, new care staff underwent a thorough induction when they started work. This included shadowing senior care workers for approximately two weeks before they could demonstrate their competence and work on their own. The Care Certificate was due to be introduced for new staff as part of their twelve months induction and to all staff to support their competence in practice. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standards of care that care homes are expected to uphold. One person's induction records were not available. The registered manager assured us the induction had taken place as they had signed the person off as competent in practice.

At the last inspection on 25 March 2015, not all staff had a clear understanding of both the MCA and DoLS. Without this people could potentially be at risk of not having their consent sought or being deprived of their liberty unlawfully. The provider had not provided training that would help staff provide support to the people they cared for, which included how to apply aspects of the Mental Health Act and DoLS in their work roles.

At this inspection, improvements had been made to the training in in MCA and DoLS. Staff had access to policies and procedures to support their knowledge. The registered manager discussed aspects of the MCA and other key training areas in staff meetings and used real life examples to support staff knowledge in this area. Staff had completed required training. They were able to explain the principles of the MCA and how to apply them in practice. Staff told us, "People have a DoLS in place when they do not have the capacity to make certain decisions, for example around their health or when people cannot go out without support." Staff said, "I ask people for their consent. When people say no, I try to empathise with them and encourage them. For example, if people say no to support with personal care, I respect their decision and come back later to encourage them to consent to this. I explain the pros and cons of their decision and help them understand information to make decisions." The registered manager discussed the MCA with staff in supervision to assess their competence.

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 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. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. We spoke with a DoLS assessor who visited the service on the first day of our inspection. They told us, "The provider has ensured DoLS renewal requests are in on time. The paperwork is appropriately completed and staff are very helpful." They said, "X is growing in confidence with staff and is benefitting from having the stability of this service."

At this inspection, we found, the registered manager had considered the least restrictive options for each individual to keep them safe when they did not have capacity to make a specific decision, for example health care decisions. The registered manager had ensured people had advocates to include Independent Mental Capacity Advocates (IMCAs) and family members. Best interest meeting were held with people, their relatives and specific health care professionals to make decisions in the least restrictive way in their best interest.

However, we found where people had bed rails in place for their safety; the provider had not obtained people's consent or completed risk assessments to ensure this restrictive practice was legally implemented. The registered manager acknowledged this oversight and was responsive to making the required improvement. Shortly after the inspection, they sent us completed bed rail assessments and consent forms for those people. It was too soon to assess whether this system was embedded in practice.

At the last inspection on 25 March 2015, menus were varied and well balanced, however, some people rarely ate what was on the menu and there was no system in place to monitor that their diets were nutritious and well balanced.

At this inspection, people were offered different choices of food. Staff had completed a food preferences questionnaire with each person that recorded their likes and dislikes. People told us, "It's pretty good actually. We have a main meal in the evening" and "I go to the hatch and staff make me tea." We observed staff asked people if they wanted a drink and they gave people what they asked for promptly. We observed lunchtime where people had decided what lunch they wanted. Some people wanted sandwiches depending on their preferences. People told us they enjoyed their lunch. People had chosen each evening meal on the menu in discussions with staff. Menus provided flexibility to meet people's needs. People were supported by staff with eating and drinking when they needed encouragement.

Where people were at risk of choking, they were referred to the GP or a speech and language therapist (SALT) when necessary, and their recommendations were followed in practice. Staff were able to explain how they supported people safely and effectively. Where needed people had adapted cutlery and beakers with straws to promote their independence and safety when eating. Care plans recorded a list of foods the person should avoid and clear guidance for staff to follow. Information was provided in an accessible format using pictures to support the person's understanding of their health need. Where there was a change of needs, the registered manager referred the person for a review of their SALT needs.

People were weighed regularly when there were concerns about their health. One health care professional

told us, "People's physical health care is very good. They make sure X [has good] fluid and food intake." Fluctuations in people's weight were noted in a dedicated care plan and appropriate referrals were made to health care professionals when needed. One person's weight had reduced during a hospital admission. This fluctuation was clearly recorded in their care plan notes. Staff were aware of this and they had supported the person to increase their weight to their normal level when they returned to the service.

People's wellbeing was promoted by regular visits from healthcare professionals. Records confirmed if people were not well, staff supported them to see health professionals. One visiting health care professional told us, "Staff prevented a hospital admission for X. "and "Staff have been concerned to ensure that they are doing the right thing. They seek out advice and manage this very well" and "I don't have any concerns and my clients are being well looked after." One health professional told us, "I have been visiting this home for two years. We developed the care plan for X. We guide the care that the client gets; liaise closely with the staff, for example around medicines and behaviours. The staff are very good at contacting us. They are good at information sharing and attending outpatient appointments. Staff accompany people, also if they require blood tests, physical checks, a member of staff accompanies them and they keep in touch with us." Where people had specific medical conditions, information was available about this within their care plan to inform and help staff understand the person's health needs.

Good

Is the service caring?

Our findings

People had developed positive relationships with staff that cared for them. One person told us, "A staff member said to me, if you're feeling down, just call me and we can talk. That was reassuring. That member of staff is really good. I like most of them [staff]" and "The night staff are excellent across the board." Another person told us, "Staff are fine." One healthcare professional told us, "Staff relationships with clients are very good and not forced. X is happy here." Written comments from relatives and visitors read, 'I found the staff to be friendly and welcoming' and 'we found the staff to be super helpful' and 'the staff are lovely.'

The staff approach was kind and compassionate. We observed staff supported people with kindness, in a positive way, showing respect for people. One member of staff talked to us about how they supported someone with their mental health needs. They said, "X has mood swings. I encourage them to talk about this. We talk about different ideas they have [to help their mood]. X loves the garden, being outside, potting plants and motorbikes. I ask X how their mood is. I encourage X when they are low in mood. X also sees a nurse to talk about how things are going." People were supported to enable effective communication between people and staff. Specific communication methods were used by staff when necessary. People had communication care plans that clearly outlined any challenges people may face and how staff could overcome this. We observed staff spent time talking with people and assessing their mood and wishes. Staff used distraction techniques to help refocus people and help them manage periods of low mood. Staff knew their likes well.

We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people. Staff used people's correct and preferred names, and spoke clearly. Some members of staff communicated with people with energy and enthusiasm. They waited for people's response and interacted positively with them. People were able to spend private time in quiet areas.

Staff spoke with people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality. People's privacy was respected by staff that knocked gently on bedroom doors to announce themselves before entering. People were assisted discreetly with their personal care in a way that respected their dignity. Staff told us, "I try and encourage people to do their own personal care where they are able. I ensure people's dignity by knocking on their doors before entering and making sure people are covered when giving personal care."

Staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and people were well presented with comfortable clothing to people's individual tastes. People completed personal care tasks where they were able to do so. People followed their preferred routine. People's care plans clearly recorded where they were able to complete tasks independently. We observed staff encouraging people to be independent when making food. They gave people encouragement and promoted their independence. Staff told us how they supported people to as independent as possible with their personal care, "I make sure X washes their face and places they can reach. I help out with areas they cannot reach."

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to. Care plans were updated following changes in health or risk based needs. People had been consulted about their care and support needs. People's rooms were personalised to meet their individual tastes. Two people showed us their room with their consent. They told us they liked their room and had chosen the décor and furnishings. One person had a double bed that they had requested and chosen, organised storage boxes and a walk in wardrobe. Another person had some photographs in their room. They said they would like to have some photographs on their bedroom walls. The registered manager said they would ensure this was addressed.

Requires Improvement

Is the service responsive?

Our findings

Staff responded to people's individual needs and wishes. One person told us, "[The manager] is gorgeous. I can tell her my problems. The emotional support that they gave me was really good. The manager sorted my benefits. She was on to them like a ton of bricks." Staff responded to any changes in people's health and care needs. One healthcare professional told us, "Staff are very much on board. If they don't know something, they will ask for help and guidance. For example they notice if X is behaving differently. They telephone for help and advice. X had a period where they had mood swings and was restless. Staff arranged a medication review, an outpatient appointment and physical tests. Two or three weeks later staff had embedded the changes which settled X. This reduced their agitations and sleeplessness. Staff keep me aware when X's mood dips."

At the last inspection undertaken on the 25 March 2015, we asked the provider to make improvements in relation to a number of areas. The home had not carried out an assessment of how each person wished to spend their day. There was no programme of activities based on individual's likes and dislikes. People told us they spent their day as they wanted. Daily records referred to a limited use of local facilities and amenities.

At this inspection, people had individual activity planners in place. They contained information on activities people had chosen and planned. People told us about activities they took part in. They told us, "I go shopping in a taxi" and "They [staff] ask me what I want to do each day. For example, I went to Hastings, with people in the home together. We went on the pier and had fish and chips." People participated in different activities. Some people liked gardening and had planted seeds in pots. One person tended to the plants and herb garden and mowed the lawns. They had a future project to paint the garden furniture, as gardening was their hobby. One person had a pet rabbit that they enjoyed looking after. People took part in weekly outings to places they had chosen. People took part in cooking and baking sessions which they enjoyed and household tasks which developed their independence skills. We observed some people making their evening meal. Staff prompted people and gave support to help people make their own meals. Two people liked to attend church and staff supported them with this. One visiting health care professional told us, "X goes out with a member of staff, does the garden and is looking at college courses." This person had attended a range of college courses. They showed us certificates of courses they had attended to include art, computers, English and work skills development courses. Staff kept records of one to one time they spent with people and the activities people got involved in.

However, one health care professional told us, "Maybe more outdoor activities [could be provided] but staff try to make it like a family environment." One person also told us, "Yes [I do activities] most days. We have board games but they get boring. Staff do ask me what I want to do but sometimes I can't be bothered. I would like a minibus, and then we could go to the park." Staff said that some people wanted to go out more often. On occasions staff told us this could not be achieved due to lack of available staff. For example, someone recently wanted to go to the pub one evening and staff told them they would have to arrange this for another time, due to staffing levels. We discussed this with the registered manager. They were responsive to concerns we reported about this. They told us they would deploy an additional staff member for certain

shift times where two staff were on shift to better meet people's needs. People's wishes to go out fluctuated depending on their mental or physical health or motivation levels. Given the variable nature of people's needs, staff were required when needed to meet people needs. Staff also told us that some staff may not always encourage people enough to do things. The registered manager had identified this as an issue and discussed this with staff in a team meeting. They told us they would continue to monitor this to ensure this was improved.

We recommend the provider reviews staffing levels and skills to ensure people's individual needs can be fully met.

At the last inspection on the 25 March 2015, we asked the provider to make improvements to ensure people's needs to include their goals and wishes were effectively progressed and recorded to promote people's skills, learning and development.

At this inspection people goals and preferences were recorded in their care plans. One person's goal was to move out of the service. They told us, "They [staff] are helping me to find somewhere else [to live]." We observed that they had telephone calls with their social worker to talk about possible new homes. They were looking at different options at the time of the inspection. They had been assessed for two different services and had regular discussions with staff and their social worker about their preferences and wishes around move on plans. Another person liked to complete college courses. They were looking to enrol on a new course for the new term time. Staff recorded people's goals in their care plan records. They recorded progress made in supporting people to achieve their goals.

Staff followed care plans that reflected people's individual needs and wishes. Information on people's care needs was included in an initial care plan that was in place when people moved into the service. One healthcare professional told us, "They take account of people's needs especially when they have new admissions. They look at the dynamics of people here." This was intended to make sure people living at the service were compatible with each other. Care plans included people's life history and what was important to them, so staff could understand people's individual needs and wishes. Specific care plans had been written in response to individual needs, such as when people may experience behaviours that could challenge, when people had specific health needs and where people wanted to attend activities.

All care plans were routinely reviewed and updated by staff. They were reviewed by the registered manager on a monthly basis or sooner when needed, such as when people had experienced an illness or an incident of behaviour which challenged. Care staff were made aware of any changes and updates at daily handover meetings. One person talked to us about how they were involved in planning their care they said, "Staff discuss it with me, about my personal care needs and my emotional support needs. [Staff] write the care plan and I sign it. " People's families or their legal representatives were invited to be involved with the reviews of their care with people's consent.

People were able to express their wishes or comment on the way staff delivered their care through discussions with staff. People were invited to comment on their care, food, activities and the environment. For example, one person had recently requested to have a dog visit the service. The registered manager was looking to access a local pet therapy service to meet the person's request. People and their relatives were invited to comment on how the service was run. A comments book was available at the service. Satisfaction surveys took place every six months and people and relatives were asked to give service feedback which was analysed by the provider. Positive comments from people included comments such as, 'the quality of food is good' and 'the quality of care is good' and 'staff are very helpful and do a lot for me' and 'there are plenty of good activities options here.'

People were encouraged to make a complaint. Information was provided to support people's understanding of how to make a complaint. Complaints had been recorded and had been investigated and responded to in line with the provider's policies and. Information on how to complain was displayed in the entrance.

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. People's decisions about who was important in their life were clearly recorded in their care plans. One visiting health care professional told us, "Staff encourage families to visit and have parties. They try to make it as much the client's home as possible and they all seem happy here."

Good

Is the service well-led?

Our findings

People and their relatives were satisfied with how the service was managed. The registered manager had been in role since October 2015. They knew people well and had a comprehensive knowledge of their needs. Since the last inspection a new deputy manager had been appointed to support the management of the service. Staff told us, "There is an open door policy here. I feel supported by the manager" and "I enjoy working here. It is a nice, small home. I know I can ask the manager anything." People we spoke with were aware who the registered manager was and we observed they felt able to talk with them and make their needs known.

At the last inspection undertaken on the 25 March 2015, we asked the provider to make improvements. Systems were not in place to monitor or analyse the quality of care provided. There were no internal quality assurance checks, such as audits. Audits are used to review the effectiveness of practice against agreed standards.

At this inspection, there was a thorough system in place to monitor the quality of service provided for people. The registered manager regularly monitored the day to day running of the service, checked documentation and observed the environment people lived in. The provider had put in place maintenance and refurbishment programme. Areas of the home had been refurbished in February and March 2016 to include communal areas and people's bedrooms. The registered manager told us they were due for further redecoration in some areas.

The registered manager completed monthly audits for infection control, health and safety, accidents and incidents and medicines. One action from a recent medicines audit identified the need for temperature readings to be rechecked in a room where medicines were stored. The registered manager addressed this to ensure the temperature was correct to keep medicines safe for use. The registered manager put in place a checklist to ensure all audits and actions were completed to support service improvements at the home.

At the last inspection undertaken on the 25 March 2015, the provider visited the home regularly and they discussed the running of the home. However there were no records of the discussions held.

At this inspection, the registered manager held monthly meetings with the provider to report on people's individual health and care needs and activities people engaged in. The report included any issues with maintenance, incidents, accidents, incident analysis, training and recruitment needs for the provider to address. The registered manager sent weekly reports to the provider to oversee audit and management quality assurance, for example on staff supervision, appraisals and training. The registered manager addressed issues that were reported and recorded actions to ensure the effective operational running of the service and improvements in service quality.

At the last inspection undertaken on the 25 March 2015, staff meetings were held regularly and provided an opportunity to discuss changes in care practices and to ensure that all staff received consistent advice and support at the same time. However, action points were not recorded to inform staff when matters had been

addressed. Whilst staff told us they found meetings very helpful and could share their views, there was limited evidence in the minutes that their views had been documented.

At this inspection, staff attended team meetings to discuss people's support needs, policy and training issues. All staff meetings were documented and recorded any actions that needed to be followed up. Outcomes were routinely recorded to demonstrate action had been taken.

The registered manager promoted continuous service improvements. The registered manager was a member of a specific association to help develop their knowledge of people's specialist health needs. Staff had received dedicated training from a specialist health nurse to develop their knowledge and skills in practice. One person's care plan needed to include communication tools and the way this was written had been enhanced by the knowledge and skills they had developed from their membership of this health association.

The registered manager described their role and their vision for the home. They were passionate about providing care to people in a person-centred, inclusive way to uphold people rights. They told us they wanted to support people with their daily needs, help people develop their life skills and independence levels. Staff shared the same vision and values. They said, "I want to help people to achieve what they want with their lives" and "I want people to maintain their independence, dignity, daily living skills and do plenty of activities." Staff understood what they were trying to achieve with people they supported to provide care in a consistent and person-centred way.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. The service's policies were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. There was a system in place for all staff to sign that they had read and understood the policies.