A C L Care Homes Limited

Camelot Lodge

Inspection report

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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

The inspection was unannounced on the first day 6 December 2016 but we arranged to go back and meet some more people who lived there on 8 December 2016.
Camelot is a residential service for up to ten people. With mental health problems. Although registered for ten people the provider had taken the decision not to use any bedrooms in a shared capacity and only nine people therefore were accommodated in single use bedrooms some with ensuites. The accommodation is arranged over four floors with no lift and is unsuitable for people with mobility problems. The service was full at the time of inspection. It is also registered to provide a personal care service to a small number of people living in supported living accommodation nearby. At the time of the inspection none of the people in the supported living were in receipt of personal care and this was therefore not inspected. Camelot is located in a residential area of Folkestone within a short walk of the town centre shops, cinema, clubs, pubs and other social activities. There is a bus terminus to a range of destinations in the Shepway area and also easy access to mainline rail services.

There was a registered manager in post who was present throughout the inspection. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality assurance audits were carried out to identify any shortfalls within the service and how the service could improve, action was taken to implement improvements, but some audits were not being carried out robustly enough and people could be placed at risk of harm because of this. Recruitment checks to ensure suitability of staff were not always completed. Emergency plans were in place so if an emergency happened, like a fire, the staff knew what to do, staff said they practiced the action to take every time the fire bell was tested, but recording of staff attendance at drills and practices is an area for improvement.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). People at the service were assessed as having capacity to make decisions and choices about their care and welfare and were not subject to DoLS authorisations. Some people were subject to community treatment orders restrictions on their movements as part of the conditions of their section and being able to live in the community. People understood their rights and choices around this and had full information regarding the appeals process should they wish to do so.

People were protected from the risk of abuse. Staff had received safeguarding training. They were aware of how to recognise and report safeguarding concerns both within the company and to outside agencies like the local council safeguarding team. Staff knew about the whistle blowing policy and were confident they could raise any concerns with the provider or outside agencies if needed.

The premises were well maintained. Equipment and the premises received regular checks and servicing in order to ensure it was safe. The registered manager monitored incidents and accidents to make sure the care provided was safe.

The complaints procedure was on display in a format that was accessible to people. Before people moved into the service their support needs were assessed to make sure the service would be able to offer them the care that they needed.

The care and support needs of each person were different, and each person's care plan was personalised to reflect their specific needs and preferences. People had detailed care plans, risk assessments and guidance in place to help staff to support them in an individual way.

Staff encouraged people to be involved and feel included in their environment. People were offered varied activities and participated in social activities of their choice. Staff spoke about people in a respectful way, which demonstrated that they cared about people's welfare. Staff knew people and their support needs well.

Staff were caring, kind and respected people's privacy and dignity. There were positive and caring interactions between the staff and people and people were comfortable and at ease with the staff. People were encouraged to eat and drink enough and were offered choices around their meals and drinks.

People made their own drinks and undertook their own personal care, including laundry and keeping their room clean. Those moving towards independence were supported to plan, purchase and cook their own meals and to gain other skills that would help when they moved out to their own accommodation. Staff understood people's likes and dislikes, promoted people to eat a healthy diet and supported and encouraged those people with special dietary requirements to adhere to them.

People received their medicines safely and when they needed them. They were monitored for any side effects and reviewed with their GP or consultant to ensure they were still suitable. If people were unwell or their health was deteriorating staff contacted the person's doctor or specialist services. People were supported to maintain good health and attended appointments and check-ups. Health needs were kept under review and appropriate referrals were made when required.

There were enough staff to ensure people were safe and received the right support day and night, this was kept under review to respond to changes in needs. Staff received appropriate induction and training to ensure they had attained the right skills and knowledge to be able to care for, support and meet people's needs.

Professionals spoke positively about the service and how well the service worked with people with chronic mental health problems. Staff told us that the service was well led and that they had support from the registered manager to make sure they could care safely and effectively for people. Staff said they could go to the registered manager at any time and they would be listened to.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The 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 consistently safe

The recruitment process for new staff was not sufficiently robust to provide assurance that only suitable staff were employed. Fire procedures were understood by staff, evacuation plans were in place, but we have recommended that participation by individual staff in practice fire drills is recorded clearly to assure provider that all staff have the right knowledge to keep people safe.

Medicines were managed appropriately. There were enough staff to support people safely. The premises were well maintained and where improvements had been identified upgrading and refurbishment had taken place to improve the environment.

Servicing checks and tests of fire, gas and electrical installations were carried out regularly. Staff understood how to recognise and respond to abuse people could be subject to. Accidents and incidents were monitored, analysed and actions taken in respect of emerging issues

Is the service effective?

Good

The service was effective

Staff said they felt supported and formal support networks through individual planned supervisions and staff meetings were in place. Staff received training to give them the right knowledge and skills to understand people's needs and support them safely.

People ate a varied diet that took account of their preferences. Peoples health needs were monitored and they were supported to access healthcare appointments.

People were supported in accordance with the Mental Capacity Act 2005 (MCA) they were consulted about their care and support needs.

Is the service caring?

Good

The service was caring

Staff responses and interactions with people were respectful, kind and considered. People's privacy and dignity was respected by staff and each other.

People spoke positively about staff support and the positive impact the service had on their wellbeing. Staff were able to spend time talking with people if they wanted and needed this.

Staff promoted people's independence and ability to do more for themselves. Staff supported people to maintain links with their friends and relatives.

Is the service responsive?

Good

The service was responsive

People referred to the service had their needs assessed to ensure these could be met. Care plans documented clearly people's needs and wishes and people were actively involved in their development and review.

People were consulted about and provided with a programme of weekly activities they could choose to participate in or not.

People said they could talk to staff and would share any concerns they had with staff if they needed to and thought these would be addressed by staff.

Is the service well-led?

Requires Improvement

The service was not always well led

A range of quality audits were undertaken to assess service quality, some of these were not completed robustly to provide assurance that service quality in some areas was being maintained and this could place people at risk.

An action plan was in place and added to every time areas for improvement were identified. A service development plan had been implemented and many of the planned improvements completed. Staff said they felt listened to and had regular staff meetings to express their views in regular staff meetings. People, staff and professionals commented positively about the service and the quality of care people received.

People, relatives and professionals were asked to comment about service quality, their comments were discussed and acted upon. Policies and procedures were kept updated to inform staff. The provider notified the Care Quality Commission appropriately when events happened.

Camelot 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 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 6 and 8 December 2016 and was unannounced on the first day of inspection. The inspection team consisted of one inspector because this was a relatively small service and people were given the opportunity to share their views with the inspector over two days.

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. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

At inspection we spoke with many of the people who lived in the service and observed how they interacted with each other and with staff. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. People had capacity and we spent time with six people who were able to help us understand their experience of the care and support they received. We also spoke with the registered manager, a team leader and three care support staff. We received feedback from two health and social care professionals who were familiar with Camelot Lodge and the support offered there. They spoke positively about the service and raised no concerns.

We looked at three people's care and health plans and risk assessments, medicine records, three staff recruitment, training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

We last inspected this service in January 2014 when no breaches of regulations were found.

Requires Improvement

Is the service safe?

Our findings

Some people we spoke with were able to make direct comparisons between this service and others they had stayed in previously, all felt this service met their needs, that there were always staff available to talk with. One person told us "I was asked about what colour I wanted my bedroom, I have a beautiful bedroom, this is the first time I have ever felt safe anywhere and it's a wonderful feeling." Another person confirmed that because they were working towards independence they had been assessed to take responsibility for their own medicines administration, but staff kept a close eye on them. People told us they were responsible for undertaking some of the household tasks, for example, cleaning their own bedroom, doing their own laundry. People thought there were enough staff to support them.

Social care and health professionals told us: "We have never had any safeguarding concerns there" and "They are very good at pre-empting situations and will phone for support and advice."

People could be placed at risk because the provider was not ensuring that recruitment of new staff was conducted in accordance with their own recruitment policy and the requirements of legislation. We checked the personnel files of three newer staff. Files contained evidence of an application, personal identification, confirmation of health fitness, a Disclosure and Barring check (this checked whether the person had any criminal offences recorded), evidence of a full employment history and reasons for leaving previous care roles had been explored either at the application stage or at interview. References were usually requested and obtained, but we found on one of the three files viewed no references had been gathered. The provider was able to demonstrate that they had sought reference feedback from overseas employers however; no response had been received from them. Not wishing to lose the skills of the person they had recruited, the provider and registered manager had taken a risk based approach to recruiting the new staff member and said that they had taken additional steps to monitor the new staff member's competency more closely; this could not be evidenced clearly within the staff file. People were placed at risk due to the failure by the provider to obtain appropriate conduct in employment references for new staff, which is a breach of regulation 19 (3) (a) of the Health & Social Care Act (HSCA) 2008 (Regulated Activities) (RA) Regulations 2014.

Staff had received fire training and this was updated annually. A fire risk assessment had been conducted. Staff knew the evacuation procedure and assembly point. Individual personal evacuations plans (PEEPS) were in place for people; these took account of their specific needs and identified the support they might need in order to evacuate the building safely. Staff told us that fire drills were held and also that mini walkthrough fire drills were held whenever the fire bell was tested. We looked at records of fire drills and found the names of staff in attendance were not recorded, similarly any staff participating in walkthrough drills undertaken at the time of testing alarm bells were also not recorded, the provider and registered manager could not therefore assure themselves that all staff had attended a minimum number of fire drills and knew the action to take in an emergency; this is an area for improvement.

Only staff trained in medicines management were responsible for administering medicines, they ensured people received their medicines when they needed them. Only senior staff were responsible for ordering medicines, receiving and booking them into the service and managing their disposal. The competency of

administering staff was assessed routinely to ensure good practice was maintained in accordance with medicine policies and procedures. Medicines were received on a 28 day cycle and were opened the first day of the Medication Administration Record (MAR). For medicines that exceeded the 28 day cycle or were received mid cycle and were in boxed or bottled packaging these were dated upon opening. Medicine storage and trolleys were kept clean, tidy and locked when unattended. MAR records were supported with information about people's allergies and a medication profile detailing what medicines people took what for and the possible side effects. Medicated topical creams needed to be stored away from oral medicines to ensure they did not leach into other medicines; this is an area for improvement. The medicine key was kept securely and transferred from shift to shift. Medicine storage temperatures were recorded to ensure medicines were stored at appropriate temperatures to aid their effectiveness.

People working towards independence were assessed for taking on more responsibility around their medicines, those assessed as fully able to self-administer were provided with their own lockable medicine cabinet in their bedroom; staff said they monitored on a weekly basis that the person was taking their medicines correctly through observation, counting medicines and checking the person's own medicine recording chart.

Staff said they thought staffing levels were appropriate for the needs of people. People told us they thought that there were always staff available to them if, and when, they needed support. Although some people were subject to various restrictions as part of their community treatment orders or mental health sections, all were able to independently go out from the service without staff support. Staffing levels were kept under review and increased if people's level of dependency required more staff input and monitoring. For example, following an incident in the service the provider had introduced a flexible twilight shift staff member to work alongside the waking night staff member if there people were very unsettled at night. The twilight staff member's hours of work were dependent on the level of activity in the service, if people were settled by the early hours then the twilight worker went home, if some people were still active and unsettled the twilight worker stayed on until the day time shift came on duty. This flexible arrangement provided assurance to staff and ensured people were supported safely.

During the daytime shifts between 8:00 am and 20:00 hours there were usually two care staff on duty; one of who was designated to be in charge of the shift. Monday to Friday between 9:00 and 18:00 hours there was additional support from the registered manager. The staff rota confirmed these levels of staffing were generally maintained.

People were protected from harm because staff had received safeguarding training that helped them to understand, recognise and respond to abuse. Staff were confident of raising concerns either through the whistleblowing process or by escalating concerns to the registered manager and provider or knew that they could refer the matter to outside agencies where necessary.

Risks people may be subject to from their environment or as a result of their own care or treatment needs were assessed; risk reduction measures were implemented and staff were provided with guidance on how to support people safely. Risk information was kept updated and reviewed with individual's monthly to re-evaluate how effective the measures in place were or whether further amendments and changes were needed to reduce risk levels further.

The environment was safe for people to live in. The premises were kept clean and well maintained, and all necessary checks and servicing of equipment and electrical and gas installations were undertaken to scheduled intervals. A maintenance team were available to address repairs quickly. Health and safety checks of the premises were undertaken on a regular basis and actions from these were added to an action

plan with timescales for completion where this needed to be prioritised. A business continuity plan was in place to inform staff what actions to take if a significant event occurred that could impact on the running of the service. A development plan had shown the need for an agreed programme of upgrading and this had been implemented and was nearly all completed, we asked the provider to make some improvement to the laundry floor during the inspection and this was carried out and completed by the end of the first day of inspection.

People were responsible for maintaining the cleanliness and tidiness of their own bedrooms and any communal areas they used, for example, the kitchen, laundry and bathrooms, a rota was also in place for smokers to take it in turns keeping the smoking area in the garden clean and tidy. Cleaning tasks were recorded for night and day staff to complete and a cleaner visited once a week to undertake a programme of intensive cleaning of all communal areas. Staff were provided with protective clothing if they needed it.

Records showed that the level of accidents and incidents in the service were low. Any accident or incidents that occurred were analysed by the registered manager for any possible patterns or trends, for example, whether there was a correlation between medicine times, or location and times of falls, or behaviour that could be challenging.

Good

Is the service effective?

Our findings

People told us that if they did not like what was offered on the menu they could have something else, a number of people were given a small budget to purchase and cook their own lunch or dinner because they were working towards greater independence. People told us that staff supported them with their health appointments. One person said about other people's behaviour, "The situation can be difficult when other people are unwell", when we asked if they felt safe or thought staff had the skills to cope at these times, they said they thought staff handled these situations well and this had made them feel safe".

A health professional told us "The staff have always been helpful, if they do not know something about my client then they will find out for me. They are always aware when I am visiting and often get the manager to see me when I am going" and "The staff have been very supportive with my client who can be quite challenging" and "They (staff) are working hard to set appropriate boundaries."

A social care professional told us "I have found them to be very good they let me know if someone's behaviour is starting to fluctuate".

New staff underwent a period of induction and were initially supernumerary on the first two or three shifts of their employment dependent on their experience, this was so that they could familiarise themselves with the routines and people's individual care regimes. Most new staff were qualified to NVQ level 2; Diploma's in Health care or social work qualifications and had previous experience of working with people with mental health needs although not always in care settings. An induction booklet was completed over the period of their probation to ensure they had the right competencies. For staff without previous experience they completed the new starter induction, which was linked to the nationally recognised Skills for Care network and the introduction of the Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.
New staff were expected to complete a probationary period of six months before they were made permanent in their role, they met with the registered manager during this period on several occasions, and this ensured that the registered manager was confident that staff had the right competencies and had learned and put into practice the skills they needed to support people safely.

The staff training record showed that the majority of staff had completed all their essential training updates in, for example, food hygiene, fire safety, infection control, moving and handling, safeguarding, mental capacity, health and safety and medicines management for those staff that administered medicines. A range of extra training both online and face to face was available to staff and a training/cinema room was available where training could be delivered, and a third of staff had completed additional training in pressure care, stoma care, person centred care and coping with aggression, to enhance their knowledge and skills and better understand and meet people's needs. Fourteen out of 20 full time, part time and flexi staff had completed or were completing nationally recognised vocational qualifications at levels 2, 3, 4 and 5.

Staff told us that they were supported through individual one to one meetings and annual appraisals of their

work performance. These meetings provided opportunities for staff to discuss their performance, development and training needs. Staff said they found the registered manager approachable and always available if there were issues they wished to discuss.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No one in the service was subject to a DoLS. People had the capacity to come and go from the service as they wished but some were in place for some people as part of their community treatment orders or the conditions of their discharge under section. Staff had received training in the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. People had capacity and made their own decisions and choices, staff provided prompting and encouragement and sometimes needed to seek consent. The registered manager was aware of actions to take when best interest meetings needed to be held, for example, necessary health interventions if a person was too unwell to make this decision for them self. Restraint was not used and staff were not trained in the use of physical interventions. Care plans made clear people's individual emotional triggers and expressions of behaviour and this helped staff understand the behaviour and the simple strategies they should use to de-escalate this to keep everyone safe.

Staff supported people with their health appointments, but if they chose to go unaccompanied then staff sought feedback to ensure they supported the person's health needs appropriately and updated their health record. People were referred to health care professionals based on individual needs; refusals to attend health appointments were recorded and would be discussed with relevant professionals as to what action needed to be taken to resolve this in the person's best interest. Staff were vigilant in checking people's wellbeing and whether there was an emerging health related need. People's weights were taken on a regular basis and any weight loss was alerted to senior staff and referred to the GP, staff encouraged people to eat healthily and were supportive of people who needed to lose weight and also ensured people with a low weight had food supplements if they were not eating well. The premises were not adapted to meet the needs of people with lessening mobility and the move towards a rehabilitative service on a shorter timescale will mean this is not a home for life and staff will work with people to move on to more appropriate accommodation for their age or physical mobility needs.

Staff prepare lunch and dinner for those who were not yet ready to take responsibility for planning, purchasing and cooking their own meals. This was cooked in the main kitchen and brought up to the dining area and kept hot in a 'Bain Marie' from which staff served meals. There was a rota in the main kitchen for those people that cooked for themselves, this showed people took turns in the kitchen preparing their own meals, but on other days ate food prepared by staff or ate out. Staff prepared meals based on an understanding of people's likes and dislikes gathered when they were admitted to the service and from changes requested by them at resident meetings or in discussion with staff. Records showed meals were varied. Staff and people confirmed that if people did not like the meal offered they could have something different of their choosing. People who were cooking for themselves had access to the kitchen and also had their own food cupboard and area in the fridge and freezer. The kitchen was locked at night as a safety precaution but, if someone wanted to cook something staff would unlock the kitchen so they could do so. At all times of the day or night a drinks area was available in the dining room where people could make tea and coffee without any restriction.

Good

Is the service caring?

Our findings

People were happy with the support and care they received. Several spoke positively about how they felt about staff, for example, "The staff are lovely." One person said about the service "They can't fix everything, they are working very hard to help us to help ourselves" and "When I am feeling emotional I know I can go to my bedroom, I can scream and shout and throw my things around and afterwards I feel so much better, and staff will be there for me."

Health and social care professionals told us: "A client of mine moved in there several months ago and I have found the staff to be helpful and informative." "They work really well with people with chronic negative symptoms" and "They liaise well I have never had any concerns." "If anything they are too good and people don't want to move on."

People were respected and valued as individuals and empowered to make changes in their lives. A person told us about how they were working towards independence and now had a weekly budget for food shopping and provided all their own meals. They felt positive about the progress they had made, but had insight into the fact that they still needed time to gain confidence in managing their own affairs.

People told us they met with their key workers and discussed their support needs each month. Staff supported with smoking cessation alternatives like e-cigarettes. Records showed people were actively involved in discussions about medicine reviews.

Some people came from outside the local health area and had not been allowed to access some health facilities, so they had to return to their home area for blood tests and consultant psychiatrist appointments in order to meet the requirements of their home office discharge arrangements, staff were supportive of the need for the people concerned not to miss these important appointments, which form part of their routine home office report, so they made time every month to take them to Maidstone or Medway.

Staff respected and were protective of people's right to speak in private if they wished. People's records were held securely. Staff showed they had a good rapport with people and spoke quietly and respectfully with them, people were encouraged to do things for themselves with staff there to advise, guide and prompt. People were given the option of having their room keys if they wanted them. Close circuit television (CCTV) was installed on the stairs and hallways, which people were made aware of when they came to visit the service. This had been installed as a safety precaution for when people became ill and could show extremes of behaviour that could pose a risk to staff and others, at which times staff needed to be aware of people's whereabouts in the building.

People's care plans contained information about the important people in their lives and important events they needed to be reminded about. Staff were familiar with their life stories and had built up relationships with them.

People had their own bedrooms and were able to spend time away from others when they wanted to; they

respected each other's privacy. Bedrooms were of various sizes and a programme of upgrading would provide more people with ensuite facilities. People were encouraged with family or staff support to personalise their bedrooms and many seen had personal effects, such as photographs, pictures, flowers, small personal possessions, and books.

People were provided with a range of information on information boards around the service, their views were sought through house meetings and in one to one sessions with their key worker (A key worker is a specific named member of staff who works more closely with the person being supported than other staff to understand their needs and ensure these are being met within the service).

People had access to a house tablet, which they could use at any time, and staff were available to provide training in how to use this if they wanted. Some people had their own IPad or tablets and iPhone so they could access the internet and keep in touch with friends and relatives.

Good

Is the service responsive?

Our findings

Health and social care professionals told us that the registered manager and staff were good at ensuring people had their regular reviews.

People had actively participated in some activities, one person told us they liked creative activities and would like to do more of that, they had been involved in making some of the Christmas decorations around the service at the time of inspection. Another person was doing a puzzle, they said they had lots of these in their bedroom and liked making puzzles and that some of them had been framed and were hanging on the wall. Two people were seen colouring pictures, which was something they had chosen to do. A fourth person told us that they liked to go to the Gym this was a favourite activity they did most days. An external musical entertainer was present for part of the inspection and people clearly enjoyed this with some singing and dancing to the music, this was a popular activity and some people from the providers other service across the street had come over to join in. Everyone was relaxed and comfortable in each other's company, one person said about the other people they lived with "We all get on well here together".

An activity planner had been developed and was displayed on the door to the dining area this included activities, such as walks and karaoke, arts and crafts, garden care, trips out and external entertainers coming in to provide musical entertainment. Some people by their own choice spent time in their rooms doing things that interested them, for example, one person liked to knit.

House meetings were held and provided people with opportunities to discuss the activities available and whether they wanted to change these or do additional activities. A record of the most recent meetings showed that many of the suggestions for external visits and activities had already been provided showing that staff were listening and acting upon what people said they wanted.

The registered manager explained that people were assessed prior to admission. Initial referrals included a current plan of care and risk assessments, additional information was also gathered from other professionals involved. The impact of the person's placement was considered and arrangements were made to meet with them informally. This was followed up with more formal meetings and opportunities for transition visits to the service. The views of staff and people already in the service were taken into consideration before a final decision to admit was made. For example, one person knew a prospective resident from a previous placement where they had not got on, this was taken into consideration not only the impact on the existing person's placement, but the impact any possible altercation may have on other people in the service and as a consequence the prospective person was not accepted. The registered manager told us that the transition of people into the service can take between three to four months with day visits, overnight and weekend stays. Pre-admission information viewed was comprehensive.

A care plan was developed from pre-admission information and this provided guidance to staff about people's daily routines; a personal profile gave staff a potted social history of the person and important events and work life that could be discussed with them. The care plan provided staff with an understanding of the person's communication style, any sensory impairments, their mental capacity and emotional

wellbeing, personal care and health care needs and activities they enjoyed. This was kept under review and added to as staff became more familiar with them and their needs. The Provider Information Return informed us that the care plans linked with people's Care Programme Approach (CPA) review documentation, which looks at their objectives, needs, aspirations, short term and long term goals. CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems. People are involved in the development of their plans and are encouraged by staff to take responsibility for working towards identified goals.

Staff took time each month to sit with the people they were the designated key worker for and talked with them about their care and support needs. Key workers wrote a monthly report and this highlighted any changes that were needed to the care plan or risk information; staff said that any changes in people's needs they became aware of were discussed with the registered manager, who amended the relevant parts of the care plans or risk assessments accordingly. Each person had a Care Programme approach (CPA) review at least annually. The provider had taken steps to provide skype facilities for those care managers or other health professionals who for reasons of distance might find difficulty in getting to reviews, and this had been used on a few occasions.

People were satisfied with the service they received and expressed no concerns. A complaints procedure was displayed for people to view. People were reticent about whether they would feel confident enough to formally complain if they were unhappy with something, but all said they found staff and the registered manager approachable and felt able to tell them about things that upset them. A complaints log was maintained by the registered manager for the recording of formal complaints received. The PIR informed us and the registered manager confirmed that no complaints or compliments had been received in the previous 12 months. People were also provided with opportunities through house meetings and individual one to one meetings with key workers to talk about things that worried or concerned them. A review of some of these meetings showed no particular issues of concern arising.

Requires Improvement

Is the service well-led?

Our findings

Health and social care professionals commented: "The registered manager keeps themselves updated" and "The registered manager and staff are always aware of when I am visiting and the registered manager is often available to see me." Another said, "The registered manager seems very good and usually meets me when I go. He seems very experienced and patient with my client."

There were a number of checks and audits in place to monitor that service quality was maintained and for the majority these were completed appropriately, however, in some instances we found that there was a risk that the checks being made by staff were not always undertaken robustly and this could place people at risk. For example, fridge and freezer temperatures had not been recorded for the first few days of December 2016; these omissions had not been picked up by either other staff undertaking subsequent daily temperature recordings or by the person responsible for monitoring that kitchen records were being maintained. Similarly the provider had implemented tasks for night staff to complete. For example, night staff were to check that tea, sugar and coffee was available in the dining area for people coming down to make drinks the next day, we heard a staff member during the morning ask for sugar, because there was none in the drinks area of the dining room and yet the previous night's task to address this had been ticked as completed.

More concerning was that although health and safety checks were undertaken regularly and these ensured that there were no trailing leads in people's rooms or over use of extension leads, window restrictors were in place, fire exits clear and no other hazards in the environment that could place people at risk. We found when looking in a laundry room cupboard two hazardous liquids; these were easily accessible to people that use the laundry on a regular basis and this placed them at risk. The failure by the provider to ensure that quality monitoring and audits were carried out robustly by staff to protect the safety and quality of the service delivered is a breach of Regulation 17 (1) (2) (a) (b) (d) (ii) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The atmosphere within the service on the days of our inspection was relaxed, open and inclusive, staff were seen to work in accordance to people's preferences and needs and their support was discreet and unobtrusive.

Staff said they found the registered manager approachable and easy to talk with. The registered manager showed that he was familiar with individual people and their support needs, he chatted comfortably with them and people seemed pleased to speak with him. Staff said they felt supported and listened to and confident that if they had any concerns these would be addressed.

Staff told us that they were familiar with the registered provider who visited regularly; they were accessible and stopped to chat with people and staff. Staff thought communication was good; they said they were kept informed about important changes to operational policy or the support of individuals usually through email, which was sent to all staff. A handover at each shift also ensured staff were given up to date information about changes in people's needs and support levels, important appointments and any immediate changes

that needed to be implemented.

People, health and social care professionals and relatives were sent surveys for their views about the service, this was usually undertaken annually, feedback was analysed and published for people and relatives to see and any actions taken as a result. We viewed a range of survey feedback received, which was positive with most rating their responses to questions about the service between excellent and good. Comments included "I am less worried about X because I know staff are there to support them."

Information about individual people was clear, person specific and readily available. Guidance was in place to direct staff where needed. The language used within records reflected a positive and professional attitude towards the people supported.

Formal staff meetings had until recently been held infrequently, the provider and registered manager had recognised the need to have more staff meetings and these were being scheduled every three months. Staff had access to policies and procedures, which were reviewed and kept updated by the provider to ensure changes to legislation and good practice guidance, were incorporated and staff said they were made aware of policy updates. This helped them to work to the requirements of the Health and Social care Act 2008 and the fundamental standards.

The providers were members of KICA (Kent Integrated Care Alliance) and a member of Social Care Commitment. A director of the organisation sat on the Kent County Council (KCC) Executive Safeguarding Board, the KCC Learning & Development Board, and the south Kent Clinical Commissioning Group (CCG) Executive Board and also a Kent based Care Association Board as well as the KCC Quality & Care Committee. They felt membership of these bodies gave them insight into plans for future mental health provision, both nationally and at local level and this informed and developed and direction of their services. They felt networking with people deciding policy enabled them to have influence in some areas. Early education about proposed changes helped them to change the way the service worked with people, allowing time for the impact of proposed changes to be lessened and people's expectations managed, for example, when grant funding for people moving into their own flats, to furnish the flat changed to a loans system that people needed to repay; this caused great anxieties, but prior knowledge of the change enabled staff to work with people and manage their anxieties around this change.

To keep updated with important information and changes to legislating and guidance the providers also subscribed to sites such as: Social Care Commitment, Skills network, CQC, Immigration News, Skills for Care, Public Sector Executive, National Health Executive to receive regular newsletters and up to date information.

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 17 HSCA RA Regulations 2014 Good governance People were at risk because the provider failed to ensure that quality monitoring and audits were carried out robustly by staff to protect the safety and quality of the service delivered Regulation 17 (1) (2) (a) (b) (d) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were placed at risk due to the failure by the provider to obtain appropriate conduct in employment references for new staff. Regulation 19 (3) (a).