N. Notaro Homes Limited

Campania

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Campania on 12 January 2017.

Campania is a large Victorian building over four floors in Weston-super-Mare, a short walk from the seafront, town and parks and is one of the provider's, N.Notaro Homes Limited, 11 services. The home is registered for up to 41 people who are living with alcohol related problems such as Korsakoff's syndrome. This meant that people required support with mental health challenges, memory loss, behaviours which could be challenging for staff and other physical effects of long term alcohol abuse. The service does not provide accommodation for people who are continuing to abuse alcohol and people sign an alcohol /illegal substance agreement before moving into the home. Therefore they knew when support could be withdrawn by the service, for example following persistent alcohol use, aggressive behaviour or engaging in illegal activities. At the time of the inspection 38 people were living at Campania with one person in hospital. People knew they were subject to random breathalyser tests and drug tests before admission. Staff, with the person's involvement aimed to provide a package of care and support that would enable people to be as independent as possible. Staff encouraged links with peoples' families, often lost when lives are disrupted by alcohol abuse, to be re-established. Few people at the home were in contact with relatives. Campania staff tried to go beyond just providing a safe home and put rehabilitation at the forefront of what they tried to achieve by celebrating those who were able to move forward into independent community living. For example, in 2016 eight people were enabled to move out to their own flats in the community with support. Staff encouraged former skills and interests to be regained and provided opportunities for new experiences to enrich the lives of people living at the home.

At the last inspection in July 2014 we found the service to be compliant with the standards we looked at. At this inspection we found the service was still meeting all regulatory requirements and did not identify any concerns with the care provided to people living at the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of this inspection the registered manager was on leave and the home was being managed by a knowledgeable and competent deputy manager.

People told us they felt safe. People expressed no concerns about their safety and were complementary about the level of support and care provided. The home had appropriate safeguarding policies and procedures in place, with detailed instructions on how to report any safeguarding concerns to the local authority. Staff were all trained in safeguarding vulnerable adults and had good knowledge of how to identify and report any safeguarding or whistleblowing concerns. Due to the nature of the service the home worked closely with local police and a community justice partnership to safely manage conflict, or anti-social behaviour, resolve issues between people living at the home and agree future actions. They also

worked closely with homeless and addiction charities, community housing support, further education and voluntary work organisations and independent advocates promoting rehabilitation and facilitated a weekly professionals 'sharing' group.

There were systems in place for the safe storage, administration and recording of medicines. Each person kept their medication in a locked cabinet in their bedroom and only staff authorised to administer medicines were allowed access. Some people were able to administer their own medication, especially if they were moving towards more independence in the community. All people taking medicines had a medication administration record (MAR) in place, which included a photograph to ensure medicines were given to the correct person. There was a medication computer system which highlighted who was due medication and alerted staff at the appropriate times, which minimised the risk of medication errors. During the inspection all records we observed had been filled out correctly and all medicine amounts tallied and were in date.

All staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We checked whether the service was working within the principles of the MCA. We found that the provider had followed the requirements in DoLS authorisations and related assessments and decisions had been appropriately taken.

Staff spoke positively about the training available. We saw all the staff had completed an induction programme and on-going training was provided to ensure skills and knowledge were up to date.

Staff confirmed they received supervision and support with their line manager, which along with the completion of team meetings, meant they were supported in their roles and good standards of care were maintained.

Observations of meal times showed these to be a positive experience, with people being supported to eat where they chose or in the dining room canteen. If people were going out or wanted a quieter experience later, this was organised. Staff engaged in conversation with people and encouraged them throughout the meal. We saw nutritional assessments were in place to ensure people were encouraged to maintain a balanced diet, and special dietary needs were catered for. Maintaining good nutrition is an important part of rehabilitation from long term alcohol abuse and people were given clear information about how a good diet could help them with their recovery.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be very caring and treated people with kindness, dignity and respect, forging relationships of trust. People who used the service were complimentary about the quality of the staff and the standard of care received.

Care plans contained accurate and detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, along with a range of personalised information which helped ensure their needs were being met and care they received was person centred. There was a focus on managed rehabilitation with external health professional support such as counsellors and community mental health professionals and it was important for people to set achievable goals. People were expected to participate and manage daily living skills such as personal laundry, cleaning and regular cooking.

Boredom is a key factor in alcohol abuse so Campania provided a supportive, structured day in a

comfortable and secure atmosphere. People could then build their own day around a core routine to promote orientation of time and place and improve motivation. People were positive about the variety and frequency of activities available, individually or in groups. The activity schedule catered for all interests and abilities and included involvement from external agencies, job opportunities and further education. A large number of activities and events had been the result of suggestions made from people who used the service. The home actively documented activities and displayed photographs of the different events that had taken place around the building.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a weekly and monthly basis and covered a wide range of areas including medication, care files, infection control and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

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.

People indicated they felt safe living at the home and with the staff who supported them. Relatives also felt safe and that situations were well managed.

People were protected from abuse and avoidable harm because the provider had robust systems in place.

Staff understood people and the triggers for individuals that could result in behaviour which could be challenging for staff. They used this knowledge and positive actions to minimise people's frustrations and promote a safe, inclusive atmosphere for people to live in together.

People benefitted from support from enough staff to meet their needs in a timely way.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Good

The service was effective.

People and/or their advocates were involved in their care and were cared for in accordance with their preferences and choices, within the remit of the admission agreements.

Staff had good knowledge of each person and how to meet their needs through effective training and communication specialising in alcohol related brain damage.

People saw health and social care professionals when they needed to make sure they received appropriate care and treatment, including during transition back to the community.

Staff had good understanding of people's legal rights and the correct processes had been followed regarding the Deprivation of Liberty Safeguards, including managing the risk of absconding.

Is the service caring?

Outstanding ☆

The service was very caring.

Staff were kind and compassionate and treated people with dignity and respect with an understanding of how people's conditions presented.

People and/or their advocates were consulted, listened to and their views were acted upon.

Where people had specific wishes about the care they would like to receive at the end of their lives these were recorded in the care records. This ensured that all staff knew how the person wanted to be cared for at the end of their life.

Is the service responsive?

Good

The service was responsive.

People and/or their advocates were involved in planning and reviewing their care. They received personalised care and support which was responsive to their changing needs and level of independence.

People were helped to make choices about all aspects of their day to day lives where they could.

People took part in social activities, had meaningful stimulation, trips out of the home (independently and supported), and were supported to follow their personal goals.

People, relatives and stakeholders shared their views on the care provided by the home. People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Good

The service was well led.

People benefited from a service with an honest and open culture within the staff team. People were the focus of service provision and seen as individuals.

There were clear lines of accountability and responsibility within the management team.

Staff worked in partnership with other professionals to make

sure people received appropriate support to meet their needs and improve the quality of their lives.

There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed and the service took account of good practice guidelines.

Campania

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 checked whether the provider was 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 12 January 2017. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by one adult social care inspector.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the home.

At the last inspection carried out in July 2014 we did not identify any concerns with the care and support provided to people who lived at the home.

At the time of this inspection there were 38 people living at the home with another person in hospital. Another person who had subsequently chosen to remain homeless was also being supported and their room kept for them should they change their mind. During the day we spoke with 10 people who lived at the home. Some people were unable to comment directly on their experience of the service due to the effects of long term alcohol abuse so we spent time observing care in the communal areas and took lunch with 20 people in the dining room. We also spoke with the acting manager, quality performance manager and training manager, a student nurse on placement at the home, a relative, a domestic and maintenance man, the cook and five members of care staff. We looked at a sample of records relating to the running of the home and to the care of individuals such as medication records, three staff personnel files, quality assurance, audits and six individual care plans.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and with the staff who supported them. One person said, "They're very good here, it's a good place. I feel ok here" and "Yes I do feel safe. I can go out when I want, which I like." One person who had recently moved to the home said, "It feels nice, you notice that when you first come in. It's friendly, easy going and nice. That's it in a nutshell." One relative said, "We think highly of the service and know [person's name] is being well looked after which is not an easy task in their circumstance."

Due to the effects of long term alcohol abuse, people required support with mental health challenges, memory loss, behaviours which could be challenging for staff and physical effects of long term alcohol abuse. Most people living at the home were male aged between 45 and 60 and were from out of the area. Some people had a history of aggressive behaviours related to alcohol abuse. A key factor in rehabilitation from the effects of long term alcohol abuse is providing a safe and secure place to live. Staff closely monitored people's interactions with each other to ensure people living at the home together and those who came into contact with them in the community were safe. For example, the service did not provide accommodation for people who continued to abuse alcohol and people signed an alcohol /illegal substance agreement before moving into the home. Therefore they knew when support could be withdrawn by the service, for example following persistent alcohol use, aggressive behaviour or engaging in illegal activities. There were clear consequences and follow up meetings recorded when this happened to minimise repeat offending, through action plans. For example, one letter to the person clearly showed why an official warning had been issued and what the person needed to do in the future to ensure they and people around them were safe. People knew they were subject to random breathalyser tests and drug tests before admission and regularly once at the home.

The provider had systems in place to make sure people were protected from other abuse and avoidable harm. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns and the local contact numbers were easily accessible. Staff were confident that any allegations made would be fully investigated to ensure people were protected. The provider had worked in partnership with the local safeguarding team relating to a recent incident, and given assurance that the person was safe, whilst enabling them to take reasonable risks with support.

When there were disputes between personalities at the home, or incidents in the community, these were taken very seriously with the support of a formal restorative justice process with the local police or local community justice partnership. For example, two people who had been in conflict had agreed a positive outcome together with their keyworkers and independent workers and signed an agreement to apologise and walk away in future. The agreement had a set review date and was included in their care plans as part of their rehabilitation goal. One person involved told us these things happen when you are not in a good place and "I'm happy the staff all look out for me. I know they want me to progress." Staff knew people's individual likes and dislikes, and were able to tell us details about how they minimised behaviours that could be challenging. For example, some people liked a quiet meal time later. This minimised the risk of people becoming upset and potentially aggressive towards others during busy mealtimes.. Other people liked to be

free and move around carrying their soft drink in a pint glass or needed regular reassurance which staff facilitated to further reduce behaviours which could be challenging for staff. Staff were also keen to praise and positively support people's behaviours and choices encouraging social inclusion safely.

Staff, with the person's involvement, aimed to provide a package of care and support that enabled that person to be as independent as possible. To ensure people were safe, this could involve a phased supportive programme to enable people to access the community safely. For example, people were involved in discussions about accompanied trips out, reducing to independent outings to ensure people were safe in the community. For example, one person who had just started going out on their own had previously been at risk of absconding and putting their health at risk. This person had decided where they wanted to go and they had chosen and a report was completed on their successful return. Their care plan showed how they had progressed from being anxious, isolated and having obsessive thoughts to increasing their self-esteem and becoming more independent. We spent time with them and they said they pleased they were doing well and feeling better with staff support. Another person was going out every morning with a support worker to get to know the area before they felt safe to go out on their own.

Staff pro-actively encouraged and supported people to maintain their independence, whether they hoped to remain at the home or move forward to more independent living in the community. Staff understood the risks people faced in order to gain independence and helped them to identify and strategies to keep themselves and others around them safe. Most people living at the home required support with daily living tasks as well as managing shopping, finances and interactions with other people. There were risk assessments in place which identified risks and the control measures in place to minimise them. The balance between people's safety and their freedom was well managed with full involvement of the person. For example, a kitchenette was used as a training kitchen, with accompanying risk assessments, to help people feel confident in making their own meals and baking. People had been supported to shop for ingredients and make cakes for charity coffee mornings for example, to encourage maintaining their cooking skills. People all had keys to their own rooms and were safely able to access the outside areas. Care plans showed what activities of daily living people could do or needed prompting with. Each element in people's care plans, such as physical risks such as mobility and nutrition and mental health challenges, described what risks may arise and how staff should address them. Some people had been identified as being at risk of self-neglect. For example, one person had poor oral hygiene due to their short term memory. Records ensured this was monitored and the person given the information they needed to prompt them to complete the task themselves. This included helping the person book their own dental appointments and prompt them to attend at the correct time. Where people chose not to agree to care plan, staff continued to support their wishes and recorded the person's views.

Staff were happy to help people if they needed assistance, but enabled people to maintain their independence for as long as possible. We saw that individual risks to people had been discussed with them wherever possible and repeated at regular reviews. For example, people's choice to smoke was well managed and people were made aware of the smoking policy. There were safety measures in place which helped people to feel they were making real choices, whilst remaining safe. One person told us how they knew they were safer if they did not keep their lighter on them all the time, and was happy to have access to one whenever they asked. When a person asked staff for a cigarette, kept by staff according to the risk assessment, staff were quick to assist and reduce people's frustrations at having to wait. People were encouraged to manage their smoking, ensuring they managed their finances appropriately and staff were available when people wanted to go to the shops to replenish.

Where people had been identified as displaying anxious or potential distress, staff used diversion techniques, for example distracting people and spending time with them or chatting about a common topic.

Risk assessments included whether people could use call bells, or whether people would choose to access the stairs or lift. All areas were accessible for people and there were no barriers, key pad codes or gates. This meant that staff were aware of risks for people and opted for the least restrictive action. Staff maintained good communication and all carried radios to ensure they were available for each other and could call for assistance.

Staff had received regular fire safety instructions and fire drills from an external qualified instructor. All care plans contained individual person evacuation plans which included details about people's communication needs, behaviours and mobility. These plans would be clear should the need arise to enable staff to keep people safe in an emergency situation.

The home was clean and homely. There was an infection control policy and staff were seen wearing appropriate personal protection equipment (PPE). Most people were independent with personal care and required promoting to manage daily living tasks. Attention was paid to detail such as covers for people's water jugs and safe storage of personal food. There were paper towels, liquid soap and clinical waste bins in use. The laundry was clean with a clear flow from dirty to clean, meaning there was no risk of cross contamination. There were washable surfaces and a locked cupboard where substances that were hazardous to health were stored safely.

Staff files showed that the relevant checks had taken place before a staff member commenced their employment. This included criminal record checks (DBS), gaps in employment and the service asked for at least two references including previous employer. This was to make sure potential new staff were safe to work with vulnerable people. The provider also conducted exit interviews for staff who were leaving. Meeting minutes commented on how these had been useful and in one instance they had been able to resolve an issue and the staff member stayed at the home.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. People's needs were met in a timely way, which was particularly important to reduce frustration and anxiety which could be a trigger for behaviours that could be challenging for staff. Staff were very visible around the home throughout the day and vigilant in observing any signs that people required assistance. We saw staff checked on people who were in their own rooms during our inspection. The provider employed a quality performance manager to oversee services and they used a staffing level dependency tool to ensure there were enough staff to meet people's needs. This could be flexible, for example, if people needed more complex monitoring, for trips out and if people had increased health needs. They supported the registered manager and came to the inspection to further support the acting manager. There was always a senior staff member on call at all times. There was a manager on duty with six support workers in the morning and five support workers in the afternoon with the domestic, maintenance, cook and kitchen assistant. An activity co-ordinator worked 9-5 each day, but this changed depending on the activity, for example 12-8 when people went to the circus.

Care plans detailed what medication was for and how people's medication was administered. There was a computer medication administration system which showed who required medication and when. Computer alerts highlighted any missed medication and reduced the risk of medication errors. Plans included information about allergies and identified risks such as refusal. Staff
noted medication refusals and informed the appropriate health professionals for review of that medication. Care plans detailed "as required" (PRN) medication and what it was for, when to give this and what actions to consider before administration. Two people at the home were able to administer their own medication as they were hoping to move into the community in the future. There were policies and risk assessments in place and eight other people were working towards this goal. Each room had a safe, lockable box to store

their personal medication.

All staff who gave medicines were trained and had their competency assessed before they were able to do so. We saw on screen medication administration records and noted that medicines entering the home from the home's dispensing pharmacy were recorded when received, and when administered or refused. This gave a clear audit trail, including which staff had administered and enabled the staff to know what medicines were on the premises. We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines. Each person had their medication administered separately. Staff explained to people what their medicines were for, especially if they had short term memory loss, and ensured each person had taken them before signing the medication record. Staff had recognised risk where one person stored medication in the side of their mouth. They had contacted the speech and language therapist and the person had been assessed and a safe textured liquid medication had been obtained. One person had their own box for insulin administration equipment which was kept safely.

Opening dates were recorded on medication with use by dates. A medicine fridge was available for medicines which needed to be stored at a low temperature which was monitored. Some medicines required additional secure storage and recording systems. These are known as 'controlled drugs'. We saw that although no-one at the home was using these at present, the home had decided to included medication with a high 'street value' to further ensure people's safety. These were stored and records kept in line with relevant legislation. The stock levels of these medicines were checked by two staff members regularly.

Good

Is the service effective?

Our findings

There was a stable staff team at the home who had good knowledge of people's needs. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. Each person moving to the home was encouraged to write their own life history and some people liked to record their own daily records. We could see people's needs were being met but daily records did not always reflect people's identified needs. The acting manager said they would remind staff to check each entry, although care plans were very person centred focussing on people's achievable goals and identified needs. Staff were also aware of what people had been doing recently. For example, staff chatted with one person asking about their time out and discussing their goals to gain further education. This helped to ensure people felt they mattered and were valued as part of their rehabilitation, whilst being secure within positive boundaries and rules.

People spoke highly of the staff who worked in the home. One person said, "Yes, I like it here. They really care for me", "We know where we are here. We can all talk like friends and I trust the staff. You can rely on them to help you" and "I can do anything really, they are helping me fill up a 'box with goodness' so I don't dwell on things. I'm enjoying it here. I'm not existing, I'm living." Other people were unable or preferred not to reflect directly on their experiences but there was a friendly, open atmosphere and people were moving around the home freely and engaging happily with staff and each other. As people moved about the home, staff engaged with them and knew what people were doing. There was plenty of space within the communal areas, four floors and patio garden to enable people to feel relaxed.

People benefitted from staff who had good knowledge about people's individual needs and especially the needs of people living with the effects of long term alcohol abuse. Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. A number of staff had attained a National Vocational Qualification (NVQ) in care or working towards a Diploma in Health and Social Care. All new staff undertook the care certificate. These are a set of recognised standards that health workers are expected to follow in their daily working life to provide safe, compassionate care. The provider insisted that staff attend training and regular updates on important subjects such as safeguarding, manual handling, food hygiene, dementia awareness and first aid. A training matrix showed staff were up to date and the administrator ensured training was booked for those due a refresher. The provider information return (PIR) also said staff did MAPA (management of potential and actual aggression) training which helped staff understand potential triggers for behaviour which could be challenging for staff and how to de-escalate situations effectively. The provider oversaw training from head office and staff were able to book on training courses from the on-going Notaro training plan.

It was also important to the provider, managers and staff that external agencies involved with the people in their care understood people's needs. For example, the registered manager had given teaching sessions to student police officers to make them aware of the needs of the service user group. This helped to break down barriers within the community and promote inclusion and understanding of the people in Campania's care. Staff also resourced places where people would feel welcome in the community and maintain their self-worth. For example, local homeless charity groups and events and church charity lunches, which some

people now accessed independently.

One care worker said, "I love it here. It's really rewarding and you make good relationships with people and see them move forward." The acting manager was really enjoying their management role and the quality performance manager praised the work they were doing. The registered manager and provider were keen to invite external professionals to run additional training sessions for staff such as administration of insulin for the benefit of people living at the home. A support worker from Addaction, a charity supporting people with addictions in the community, visited the home regularly to carry out individualised reviews with people and give independent advice and support.

Each new staff member received a comprehensive induction using workbooks in line with national guidelines. A new starter programme would include a week in the classroom with a further supernumerary week, or more if needed, in the home shadowing more experienced staff. Staff received regular one to one or group supervision where they could discuss issues such as their training needs. There were annual appraisals preceded by staff self-reviews which were then discussed and incorporated into a personal development plan.

The home was well maintained and provided a pleasant and homely environment for people. Staff noted issues in a maintenance book which were dealt with in a timely way. There were different places for people to spend time such as a quieter room, large lounge, conservatory/activity area and TV room. People who lived in the home were involved in choosing colour schemes and furnishings. People had been supported to shop and decorate their own rooms. One person was happy to show us around their homely room.

People had the equipment they required to meet their needs. Most people were independently mobile but there were grab rails and hand rails around the home to enable people to move around independently. There was no assisted bath but a shower chair and wheelchairs were available for those people with mobility problems. People chose whether they wanted their name on their door, or so some people had numbers as they wished. People could access all areas of the home freely depending on their risk assessments and people had individual walking aids to support their mobility. The garden had a secure patio area with a smoking shelter and was safe for people to access independently. People were coming and going as they wanted to.

People had access to health care professionals to meet their specific needs. Records showed people had access to appropriate professionals such as GPs, dentists, district nurses and speech and language therapists (SALT). For example, staff recognised when people needed a thinner textured diet to minimise the risk of choking and referred the person to the SALT team. People were able to choose their own GP. The acting manager said they had a good relationship with local GPs and could be assured that telephone messages would be picked up promptly. People said staff made sure they saw the relevant professional if they were unwell. There were regular reviews of people's health and staff responded to changes in need. One person with diabetes had been regularly monitored for example, and the chiropodist and GP had been involved. Staff had been trained by the community diabetes specialist nurse in insulin administration. This reduced people having to wait for the district nurse to visit. The specialist nurse then visited to monitor people's blood sugar levels and review the care. The acting manager was very knowledgeable about diabetes care in particular and gave examples of how people's health had improved, such as requiring less insulin and maintaining a more stable blood sugar level. This demonstrated the staff were involving outside professionals to make sure people's needs were met.

The acting manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal

rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well, and other professionals, where relevant. The care plans clearly discussed mental capacity and what people could understand and retain. For example, care plans detailed the level of understanding each person had and whether there was a named representative with power of attorney. Throughout the day staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes. Five people required some restrictions to be in place to keep them safe. The registered manager had made appropriate applications to the local authority to deprive people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and people's advocates. Staff continued to involve people in decision making which they could understand such as choices of clothes and food and drink or what they wanted to do. Even if people had been assessed as unsafe to leave the home independently, staff still enabled them to go out safely with support if they wished, for example, to the shops or for a walk. DoLs were regularly reviewed, with care plans clearly showing any progress made towards safe independence.

Each person had their nutritional needs assessed and met. Korskoff's syndrome (brain damage due to long term alcohol abuse) is often caused by a lack of vitamins. The Campania guide stated that the emphasis was entirely up to the people living at the home but staff actively promoted a healthy, balanced diet. A 'Campania get Healthy' campaign was on-going. People could choose to participate in weekly weigh-ins like an in-house slimming programme.

The home monitored people's weight in line with their nutritional assessment. Records identified nutritional risks using a nationally recognised tool and monitored people's progress. The kitchen staff were aware of who had special diets such as diabetic or high calorie. Diets were very personalised. Meals were home made using fresh fruit and vegetables and meat from a local butcher. There was a wide range of choices and people were able to suggest meals to include on the menu. The home also held themed nights such as Italian or Chinese meals. We took lunch with 22 people. This was a sociable event in a pleasant environment with nicely laid tables. Staff took account of where people liked to sit and who with. People were not rushed and were treated with dignity and respect. Condiments and drinks were available. There were also snacks which people could access in between meals if they wished. Everyone we spoke with was happy with the food and drinks provided in the home and enjoyed the lunch of chicken and vegetable casserole, vegetarian chilli and rice and a dessert choice of syrup sponge and custard or peaches and ice cream, all served from a self-service hot trolley. People were offered second helpings. Support workers also spent time making people teas and coffees whenever they asked and regularly asked people if they wanted drinks throughout the day, not just at set tea and coffee times.

Outstanding ☆

Is the service caring?

Our findings

People were supported by very kind and caring staff. Staff talked with us about individuals in the home. They had an excellent knowledge of each person and spoke about people in a compassionate, caring way. One person said, "They all do a good job." Another person said, "I love how I'm treated as a person, down to earth. I'd rather have pretend brick wallpaper [pointing to wall] than pretend people. The staff make me feel happy, 'health and happiness', I can get both in this building." A relative told us that, "Campania do an excellent job in difficult circumstances. There are consistent faces and they are always welcoming. All the staff understand [person's name] and look after them well, they promote our relationship. They allow [person's name] to be who they are!" Throughout the day we saw staff interacting with people who lived at the home in a caring and professional way with lots of humour and banter. The acting manager said, "It can be challenging but I love being active and hands on. I need to 'know' people. It's a fast paced job but it works for people and I love it." They were enjoying the challenge of managing the home in the registered manager's absence. Staff were clearly proud to tell us about how individuals had made progress in their goals. An activity worker told us how they had been trying to engage with one person who was too anxious to go outside the home. The day before they had been to the corner shop with the activity worker, which was a huge milestone for the person. One staff member said, "I want [person's name]'s care plan to be spot on so we can show the GP." Staff really cared about people as individuals and their progress in living a meaningful life. For example, one person had made a choice that could put them at risk in the community. They had chosen to remain homeless and the home had kept their room available and were discussing with external agencies how to support the person in a way that was acceptable for them, minimising potential risks as much as possible for them to have the life they had chosen.

There was a good rapport between people, they chatted happily between themselves, and with staff and management. Staff knew people's personalities, who they liked to spend time with, what they preferred to do and individual routines. For example, one person preferred to spend all their time in their rooms except when they picked up their meal. It upset them if staff continually tried to coax them to join in so staff knew how to manage them and left them alone when they preferred to be alone, popping back later. They celebrated the time when the person did join in, noting what had prompted this choice. Staff were also pleased to tell us about people who had finally been able to see their children due to positive progress, when their behaviours had not allowed contact previously.

Staff supported people who were anxious or distressed in a sensitive and discreet way. They sat chatting with a person to find out why they were feeling particularly anxious and what could they do to help. The person was visibly calmer a few minutes later. One person responded well to a reward chart related to obsessive and repetitive behaviour that could be distressing for the person. Staff had made the chart with the person adding smiley faces as the person wanted. This person was now able to go out to the shop, choosing the same time every day which had improved their mobility and exercise.

Some people used communal areas of the home and others chose to spend time in their own rooms. People had a call bell to alert staff if they required any assistance. They told us these were answered quickly although few people used the call bells as they were independently mobile. People's privacy was respected.

All rooms at the home were used for single occupancy, some with en-suite. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. We saw that bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care or having private discussions. A telephone was available in a private, quiet area. Staff always knocked on bedroom doors and waited for a response before entering. Some people had do not disturb signs and these were respected. Staff noticed people's body language and attended to them to minimise any anxiety or distress. The PIR said there was a dignity champion and this named staff member updated staff on their practice and promoted consistent care.

We saw people were able to make choices about their day to day lives. Most people devised their own structured routines which helped people living with alcohol related brain damage to feel secure and safe. Staff knew people's individual routines. For example, one person did not like breakfast and preferred to lie in, having a good meal at lunch and dinner. People chose what time they got up, when they went to bed and how they spent their day. Care plans showed details about people's choices, and there was a comprehensive picture of people's preferences with their involvement. When people regularly forgot things staff reminded them. For example, if people lost track of their conversation staff reduced their frustration by spending time doing activities with them.

Staff were sensitive to how people felt. For example, people did not always want staff to have their ID badges on show when they accessed the community with support. It was agreed that staff could just ensure they had ID available. People were also updated on any changes within the home such as new staff. Information about memory boxes was shared. Staff were helping people to make memory boxes where they could store mementoes and special items to promote remembering. Staff promoted inclusion in the community as a whole. People were included in local fundraising events which they said they enjoyed and made them feel useful. One staff member invited people on a charity walk with them.

Staff ensured people communicated effectively, ensuring they were wearing their glasses and hearing aids for example. Where people expressed different choices their care plan was updated to the new routine but staff continued to offer a range of choices to enable people to change their minds. There were details of how to offer choices which people could understand. For example, there was a plain speaking guide to Campania. This was called 'Everything you ever wanted to know about Campania but couldn't remember who to ask'. This used respectful language in a non-patronising way reassuring people that memory loss was a common symptom of long term alcohol abuse and that although there was no cure that once stopping alcohol consumption there was a chance of improvement. The guide stated, 'One of the aims of this guide is to also help you understand the people around you'. This helped people to settle into the home and feel safe and cared for. It made it clear that staff would not force anyone to do anything but encourage them to develop their own structured day, to look after themselves and improve their self-respect saying it is 'up to you'.

People were very involved in decisions about the running of the home as well as their own care. The Campania brochure given to people living at the home was called, 'Supporting you towards independence' and this was the focus of the home. There were case studies showing people's positive experiences so that people could see 'rebuilding their lives' with support was possible. Some people had physical effects of long term alcohol abuse related to accidents sustained under the influence. Staff supported people to manage these in a caring way and highlighted positive progress to individuals to encourage them such as a reduction in seizures and gaining work experience for the first time in many years. The registered manager said in the brochure, "The changes Campania can help to bring about in people's lives make all the hard work hugely worthwhile. When we see families re-establish relationships and made complete again we

know we've made a lasting difference." The acting manager told us about one person whose family they had helped them find. Relatives told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in their own room. There was also a quiet lounge upstairs which some people chose to use to see visitors or health professionals.

People were supported to talk about their past and work through any issues, with professional help if needed, whilst respecting the wishes of those people who did not want to talk about it. This was especially important as most people at the home had lost touch with their loved ones due to their destructive history and may have low motivation to progress. People were able to participate in positive activities such as 'making amends' writing letters to people they may have upset in the past due to their condition and comment in their care records what they were happy about in life to create a positive mind-set. Staff sought out specialist support for some people, such as counselling for people who had suffered domestic abuse and other external community therapeutic services.

Staff encouraged people to be as independent as they could be as part of their on-going goal setting. The fourth floor rooms were used for people who may be moving on and they were supported to self-manage as much as possible. We noted that staff never spoke about a person in front of other people at the home, which showed they were aware of issues of confidentiality. They acknowledged people as they moved around the home engaging in chat that was familiar to them, for example about places they had been or things they liked to talk about.

Residents meetings were formally held twice a year but the registered manager had an open door policy and people said they felt happy to talk to anyone at any time. Staff said when people wanted to talk it was important to give them the time they needed, to maximise communication. People could discuss any subject although usually spoke about activities and trips they would like to take part in and food they would like to see on the menu. For example, a fish and chip takeaway was organised from a suggestion. There was also an anonymous suggestion box.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. There was information which showed that staff had discussed advance care planning with people. Appropriate health care professionals and family representatives had been involved in these discussions. Other information included if people wanted to be involved in medical research, advance declarations of end of life choices, special instructions for funeral services and clearly stated when people had said they did not want to talk about this topic any more. Staff also supported people and staff in the home if there was bereavement. A recent sudden bereavement had been difficult for everyone and staff were available to talk to people about it, celebrate the person's life and attend the funeral. The acting manager had worked a night shift to enable night staff to visit the person in hospital before they died. They had taken them balloons and gifts and clearly the person was cared about.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs because staff had excellent knowledge of the people who lived at the home. One person reviewing the home on an independent website said, "Individual care and overall care good. Encouraged to develop own interests and independence." And they were 'extremely likely' to recommend the service. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations and that people knew what was expected of them in return. They were also supported to complete pre-admission detox if necessary. Staff considered the needs of other people who lived at the home before offering a place to someone to ensure they could meet everyone's needs effectively.

Care records were personal to the individual, which meant staff had details about each person's specific needs and how they liked to be supported in a person centred way. For example, the home used a '3 step enablement programme assessment- The Way Ahead'. This had been devised by the provider working with specialist advisors and using their own experience in providing care for people living with the effects of long term alcohol abuse. People were assessed on seven main skills including mental health and capacity, personal hygiene and self-care skills, social development skills and moving on. Each skill area was split into three levels to determine ability and understanding. For example, level 1 – cannot or will not demonstrate skill/can demonstrate skill with staff input. Each skill area had a set of assessable areas such as, under personal hygiene and self- care skills; awareness of own appearance, oral hygiene and ability to identify appropriate skin and hair products and use effectively. Therefore people could see areas to work on and where they had progressed. One person's summary said, "[Person's name] would not be able to purchase their own toiletries or use if they were not purchased for them as they choose to buy other things" and "[Person's name can shave themselves and complete the task but requires support to change their clothes and do their laundry." Moving on sections discussed what people would like to do in the future and the barriers to them being able to do it effectively and safely. For example, if they would be at high risk of self-harm or neglect due to a lack of insight and understanding of their condition.

People were also supported to attend support groups in the community and the home worked closely with Addaction, a UK based drug and alcohol treatment charity, helping people to achieve recovery. When people living at the home received advice and leaflets or had followed a programme such as 12 steps (a nationally recognised alcohol de-tox recovery programme) in the past, staff helped to remind people about this advice. The home were working on a leaflet with Alcoholics Anonymous, (a community fellowship who enabled people to meet and share experiences, strength and hope for people recovering from alcoholism) that would be more suitable for people living with short term memory loss.

People living at the home and/or their advocates were involved in planning and regularly reviewing their care with their named key worker. We saw people's care plans were discussed with them three monthly or sooner if needed and changes were made if necessary. People had been able to sign their care records and the record of each review. Records were very detailed using a comprehensive assessment review check list. For example, detailed review records gave a clear picture of how the person was achieving their goals such

as reducing aggressive behaviour and progress with self-care management. The person had begun to eat more regularly and areas to work on to regain further independence were highlighted such as ensuring they listened to health professional advice in managing a wound to prevent infection. Staff were aware of people's care plans and risk assessments and provided care in line with these assessments. Staff knew what physical assistance people required, including gentle reminding to use their frames or sticks to keep safe. One person said they needed an eye test so staff chatted about when would they like to go, did they know how to arrange a test, did they want company, offering a trip then and there or were they happy to go on their own.

People were supported to maintain or re-kindle contact with friends and family. Visitors said they were able to visit at any time and were always made welcome. People were encouraged to be involved in the local community. Staff encouraged people to use local facilities such as shops and cafes. One person said "I can go out when I want now. I made some not great choices in the past so staff had to come with me but I think I'm over that now. The staff are pleased I'm doing well."
This mirrored their care plan.

Staff at the home responded to people's changing needs. Care plans were kept up to date and staff also responded promptly to signs that people needed assistance. For example, one person became anxious and had a history of aggressive behaviour. Staff immediately went to chat with them, guide them away from a busy exit area and offered them a cup of tea which diffused the situation. Any actions taken were recorded in the care plans, which showed regular medication reviews for example.

Boredom can be a key factor in alcohol abuse so Campania provided a supportive, structured day in a comfortable and secure atmosphere. People could then build their own day around a core routine to promote orientation of time and place and improve motivation. People were positive about the variety and frequency of activities available, individually or in groups. The activity schedule led by an activity co-ordinator catered for all interests and abilities and included involvement from external agencies, job opportunities and further education. A large number of activities and events had been the result of suggestions made from people who used the service. All staff had an on-going responsibility for ensuring people received individualised engagement and stimulation.

Throughout the day staff provided individualised meaningful occupation with people, noticing whether people were tired, wanted space or whether they would like to do another activity. For example, in the large lounge/conservatory during the inspection a support worker was doing a word game with a group. Some people liked to watch, others were playing scrabble, reading the newspaper or chatting with others in the smoking shelter. The programme of activities was on the notice board. A 'Creative Campania' programme was also on the notice board. This was an arts and craft opportunity for people to share poems, have art exhibited and generally promote a celebration of people's talents, 'show off your hidden talents'. One person said they used to love drawing and was planning a picture. There was a hairdressing salon with a visiting hairdresser once a month, where people could also enjoy 'pampering' sessions. A large pool room and library was popular with people and people organised their own pool competitions. One person told us they had done all the gardening and made a vegetable patch.

People were supported to access further education and signposted to accessible courses to help them move towards possible employment. One person was on an information technology' course (IT) and was being supported to retain information. The home had a quiet computer area with access to wi-fi and the internet whenever people wanted. People were supported to access voluntary employment opportunities and the staff worked with the volunteer agency to ensure people's needs were met in a positive way.

There was a wide range of organised events from external entertainers and regular trips out in the home's people carrier. For example, throughout the inspection various people were going out, to the bank for supported financial management practice or for a drive. One support worker said it was important to enable people to get away from the four walls and have a change of scenery. The activity worker said they got the local newspaper on Thursdays and went through any opportunities with people, choosing what events were available. People had been to car shows, attended pottery courses, for example. The activity worker said they loved their job, having started recently. They enjoyed researching opportunities, getting people's ideas and doing them. Most people came from out of the area and staff also organised trips 'home'.

People said they would not hesitate in speaking with staff if they had any concerns. The service user guide and notice boards gave details about how to raise a complaint. Complaints had been taken seriously and responded to in line with the provider's policy. The complainants had been advised of the outcome of the complaint investigations. The PIR stated that the registered manager was also going to record verbal compliments to share with staff.

Good

Is the service well-led?

Our findings

People and their relatives were very complimentary about the management team and staff at the home and the positive culture they had developed that ensured people were at the heart of where they lived. There were positive signs that people living with the effects of long term alcohol abuse were valued and supported to improve their quality of life. This was through individualised care, rehabilitation and pro-active ways to promote real independence in a safe way. People who were able to leave the home to move forward in the community were celebrated and many had been enabled to move into their own flats with support. A person had said in the recent annual review, "Staff are lovely. They make me feel safe and I am who I am because of them." People commented, "They all do a good job" and "It's good here, they're all nice, I like going to help in the kitchen. They know I like to be busy." One relative was happy to tell us what a great job Campania was doing. They said, "They do an excellent job in difficult circumstances. [Person's name] can be who they are, they understand them and they are well looked after. I talk to [acting manager] a lot, they promote my relationship with [person's name] in a positive way. I see consistent faces and I can go home knowing everything is ok."

There was a management structure in the home which provided clear lines of responsibility and accountability. The registered manager had been registered with CQC August 2016 and was supported by a deputy manager (currently acting manager), team leader, senior support workers and a more stable staff team for the last year. Robust quality assurance systems ensured the staff were competent and the service made on-going improvements to maintain good standards overseen by the provider audits. The provider's management team at head office regularly monitored the service and ensured the registered manager was doing a good job. A regular overall quality performance review was carried out by them. The registered manager said in the Provider Information Return (PIR) they were well supported by the provider quality performance manager who was always willing to listen and offer support. The provider quality performance manager visited Campania during the inspection to further support the acting manager and staff team.

The quality performance review was very detailed and followed CQC standards and regulations, highlighting good practice and making suggestions. The review in December 2016 resulted in all 'good' outcomes, using the provider's rating system. For example, it highlighted improvements made in record keeping, supervisions and cleanliness, thanking staff for their good work. Comments at the last review had highlighted omissions in record keeping and this had then been raised in a staff meeting and improvements made. Staff were also auditing people's dining experiences sharing lunch with people to ensure people had positive mealtimes. There were also regular managers' meetings for support and to discuss and share information.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care including medication audits, care plans audits and falls. A master audit plan ensured these were all up to date with allocated staff responsible for various audits. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. For example, where people had fallen risk assessments were reviewed and preventative measures taken. There was also a complaints audit to look for any themes the

service could further address. The provider employed a lead for complaints and concerns and family liaison issues. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

Staff, throughout the organisation were encouraged to strive towards 'outstanding' care. The provider had invested heavily in Campania such as re-furbishment and new computer systems in medication, staff attendance and were looking at new dependency tool systems. They also praised staff, for meeting high standards and achieving positive inspections, for example. When the registered manager made requests to the provider these were listened to, for example staff would like a sticker with the home's contact details on the back of their ID for when they went out with people. This was being sourced.

Staff told us, and duty rotas seen confirmed, there was always a senior care worker or manager on each shift. Staff said there was always a more senior person available for advice and support. Staff were happy working at Campania. Two staff told us, "We love it here. We drive a long way but management and staff here are lovely. We love [the acting manager]. What you see is what you get which is right for this home. We all chip in and help. We are a team." The acting manager expressed a love of their job and determination in their new management role and showed enthusiasm in wanting to provide the best level of care possible. They told us how well one person had done, 'if you gave them a word to start a conversation from, they could remember more' and there had been positive visits with the person's family. They told us how routines were important for people, especially those new to the home and orientation was a big part of the initial days. One person new to the home was now able to find the dining area independently which helped them settle in. Staff had adopted the same ethos and enthusiasm and this showed in the way they cared for people. One staff member said, "She [the acting manager] knows people inside out!" The acting manager said of staff, "They are amazing, especially the seniors. I'd be lost without them."

Staff were formally supported during one to one or group supervision sessions. These were completed regularly and detailed information with a regular agenda about staffing issues, training requirements and staff competency. Where issues had been identified such as practice issues or staff behaviour, these were discussed and actions taken and followed up. There were regular team meetings and good communication between the team. For example daily allocation sheets highlighted staff roles each shift, ensuring tasks were done such as assisting people to pack or book the dentist. Staff met regularly with health professionals in 'share groups' to share information to benefit people in their care. The registered manager ensured staff were happy in their job, giving them opportunities to give feedback. For example, at a medication meeting staff reminded others not to distract staff whilst they were administrating medication.

The acting manager continued an open door policy and they were available to relatives, people using the service and health professionals. They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. For example, providing training for student police officers and actively seeking independent advocates for people. They were very knowledgeable about the type of people living at the home and how they presented, using communication skills which were effective for a complex group of people. Due to the nature of the service, tensions between people living at the home could rise and the acting manager was excellent at diffusing situations with humour and understanding people. Staff also resourced places where people would feel welcome in the community and maintain their self-worth. For example, local homeless charity groups and events and church charity lunches, which some people now accessed independently.

There were systems in place to share information and seek people's views about the running of the home. An annual satisfaction survey took place. There had been a low response from the recent questionnaire in July 2016 so the staff were trying to find other ways to increase people's feedback. There had been requests

for more activities so the home had completed an action plan. People had been assisted to obtain bus passes, offered more activities, with more uptake to a gym, there had been a reptile handling session and a talk was organised for the fire brigade to come and give a talk on fire safety which was very popular. Activities were also discussed in resident's meetings. This all enabled the home to monitor people's satisfaction with the service provided and ensure any changes made were in line with people's wishes and needs.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.