Isle of Wight Council

The Gouldings

Inspection report

The Gouldings
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Gouldings is a local authority run care home for short term respite and reablement support. Reablement is a way of helping a person to remain independent by giving them the opportunity to re-learn or regain some skills for daily living that may have been lost as a result of illness, accident or disability. The home provides accommodation for up to 35 older people, including people living with dementia. At the time of our inspection there were 18 people living at the home.

The Gouldings also provided a reablement service for a limited period in a person's own home that included personal care; help with activities of daily living, and practical tasks around the home. At the time of our inspection they were supporting 27 people in their own homes, 10 of which were considered to have 'long-term needs' and were waiting to be passed on to another private care agency

The last inspection of the service, which took place over 31 March, 02 and 07 April 2015 identified a breach of the regulations in respect of managing the risks relating to a person living at the home. The provider told us they had taken immediate action to ensure they were compliant with the regulations.

At this inspection, which was unannounced and carried out on 20 July 2016 we found that all actions in respect of the breach had been completed.

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

The risks relating to people's health and welfare were not always fully assessed for people being supported in their own homes. The risks relating to people in the residential part of the service were personalised and provided sufficient information to allow staff to protect people in the least restrictive way whilst promoting their independence.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner. People were supported by staff who had received an induction into the service and appropriate training, professional development and supervision to enable them to meet people's individual needs.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines

were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff sought people's consent before providing care and understood the need to follow legislation designed to protect people's rights.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. In the residential part of the service mealtimes were a social event and staff supported people, when necessary, in a patient and friendly manner.

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when engaging with people who had difficulty in communicating verbally.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback about the service provided. This was both on an informal basis speaking to people and through a survey completed by people using the residential part of the service at the end of each period of respite and by people supported in their own homes when they were discharged from the service.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the service. They were also supported to raise complaints should they wish to.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The senior staff had not always fully assessed the health risks to people using the service. Where people were supported in their own homes individual environmental risks were identified.

There were enough staff to meet people's needs and a duty roster system provided the opportunity for short term absences to be managed.

People and their families felt the service was safe and staff were aware of their responsibilities to safeguard people from abuse. People received their medicines at the right time and in the right way to meet their needs.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and when necessary followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important

relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on people's individual needs and preferences.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

The Gouldings

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 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.

The inspection was unannounced and was carried out on 20 July 2016 by two inspectors and a specialist advisor who had experience and knowledge of working with, and supporting older people.

Before the inspection, the provider completed 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

The service provides a mixture of residential care and the provision of care in people's homes. We spoke with a total of eight people using the service and the relatives of two others. We also spoke with three health professionals. We observed care and support being delivered in communal areas of the home. We spoke with five members of the care staff, two reablement leaders, two reablement coordinators, three assistant managers, the chef and the registered manager.

We looked at care plans and associated records for 13 people using the service, staff duty records, four staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

The service provides a mixture of residential care and the provision of care in people's homes. At our last inspection we identified that the provider had failed to ensure there was an effective system in place to identify and mitigate risks relating to the health and safety of people using the residential part of the service. At this inspection we found that people in the residential part of the service were protected from individual risks in a way that supported them and respected their independence. The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example one person, who usually self-mobilised but was at risk of falling due to an infection, had a risk assessment in place in respect of the support staff should offer to help them mobilise until they were able to self-mobilise again.

Staff who supported people in their own homes told us comprehensive risk assessments were completed to manage risks posed by the environment. They carried Residual Current Devices (RCDs) to use with electrical equipment where the safety of the home's wiring could not be guaranteed. One staff member told us they had used this in the past for a kettle that posed a risk. However, risk assessments in respect of meeting people's health care needs did not always identify individual risks to people, such as the risk of falling in their home. One person had a history of falling but there was no guidance in their care plan to advise staff how to support the person to reduce this risk. Their care plan stated the person could "use stairs with one carer support" but it did not detail how the member of staff should support the person to ensure they and the member of staff remained safe. We raised this with the registered manager who agreed to that this was an area for improvement.

Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents.

People across the whole of the service told us they felt safe. One person said, "Yes, of course I do feel safe here". They added "Everyone knows me; I have been coming here for years". Another person told us, "I feel safe just being here because I live on my own. A third person said, "I always feel safe". A family member said, "People feel safe here. They are well cared for and some don't want to go home". A health professional told us, "Yes, absolutely [safe]. The clients love it here, they like coming in here". A member of staff told us, "Yes, my mum also comes here and I feel they receive safe care".

People across the whole of the service experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. Staff were clear about their safeguarding responsibilities and knew how to raise observed concerns and to apply the provider's policy. One member of staff told us if they had any concerns, "I would tell the assistant manager or the manager". They added, "I know I can go higher if nothing happens". Another person gave us an example of where they had raised a safeguarding concern about a family member. They explained that they knew the family member would not be happy and said, "It wouldn't put me off raising a concern again. The person

was very vulnerable".

The registered manager explained the action they would take when a safeguarding concern was raised with them and the records confirmed this action had been taken when a safeguarding concern had been identified. The registered manager had reported these concerns to the appropriate authority in a timely manner.

People and their families across the whole of the service told us there were sufficient staff to meet people's needs. Their comments included, "Yeah plenty of staff here", "My son's always happy when he knows I am here. He knows I am being looked after" and "There is always plenty of staff around if you need them. If I ring my buzzer staff come quickly to see what I need".

Staff who supported people in their own homes told us that once they had arrived they had ample time to provide the necessary care and support to people. One staff member told us, "I never feel pushed because it takes as long as it takes [to provide the necessary care]. We usually work in one area, so there's not too much travelling involved." A senior staff member said, "We only take on cases we have capacity to manage, including travelling time [for staff]."

The registered manager told us that staffing levels were based on the needs of the people using the service. The staffing levels across the service provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed. For the residential part of the home this was managed through the use of overtime, staff employed by the provider at other homes and the provider's bank staff. The short term absence of staff providing support in people's homes was covered by other members of the team. The registered manager was also available to provide extra support when appropriate. When staff who provided support in people's homes had some spare time, they helped support people in the residential side, for example by helping to bath people, run entertainments etc.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The registered manager had a process in place to review the DBS checks annually to identify whether staff circumstances had changed.

People across the whole of the service received their medicines safely. One person said that staff, "help me with my tablets. They are very good with that. They are always on time". However, when people chose to self-administer their medicines, such as inhalers, the risks associated with them doing so were not always documented. We raised this with the registered manager who took action to ensure the documentation was completed in future.

Staff had received appropriate training and their competency to administer medicines had been assessed by the registered manager to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe

storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Good

Is the service effective?

Our findings

The service provides a mixture of residential care and the provision of care in people's homes. People and their families, across the whole of the service told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "Staff are very experienced here." Another person told us that staff were "very experienced, I am surprised how good they are". A person receiving support in their own home said, "I find [staff] are very good and they help me with [my goal to cook independently]". A family member told us, "I would thoroughly recommend [the staff]. They showed me how to manage [my relative's] catheter and it's given me confidence. I'm well pleased with the help I got". Another family member said, "Staff understand [my relative's] needs. She wouldn't come here if they didn't". A health professional told us that staff were "mindful of their [people's] needs and they are always supportive".

When appropriate people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. The registered manager told us that none of the people using the service lacked capacity to make their own decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was aware of the necessary requirements. However, none of the people using the service required DoLS application to be made. Staff had been trained in MCA and DoLS and were aware of their responsibilities under the Act. One member of staff told us, "We assess people when they come in to know what their needs are. We do not have anyone who lacks capacity". Another member of staff said, "We are monitoring people at all times and any changes will be reported to the management team. People will lack capacity if for instance they have an infection causing them be confused".

People and their families told us that staff asked for their consent when they were supporting them. One person said, "Staff are very good, caring. Like this morning when they helped to cream my legs. They always check first and ask if it is okay". Another person told us, "I used to work here so I know what to expect. Staff are very good and always offer me a choice [of whether I have care provided or not]". Staff supporting people in their own homes told us that when they spoke with the person, they checked the person understood any decisions they were asked to make. People receiving support within their own homes were able to make decisions independently or with a little support from their families.

Staff sought people's consent before providing care or support, such as offering to provide support to help

them mobilise. We observed staff seeking consent from people using simple questions, giving them time to respond. Care plans included signatures from people indicating their agreement with the care and support that was planned. When their care was reviewed and changes were made, they were invited to re-sign the record to show that they had been involved and had agreed to the changes. Daily records of care showed that where people declined care this was respected.

People across the service were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. A member of staff told us, "Training has been hands-on and the [staff] I shadowed were very experienced and very helpful". Staff who were new to care, received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness, Mental Capacity Act and deprivation of liberties safeguards, end of life care, falls prevention and catheter care. Staff were also supported to undertake a vocational qualification in care. One member of staff told us, "I found the end of life training really helped. It let me know what to expect, what people may want to talk about and how to support family members. You have to be a good listener". Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who had difficulty in mobilising to maintain a level of independence.

Staff across the whole service had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff said, "I have monthly supervisions where we discuss my workload, if I'm happy with work, whether I need any extra training or if there are any improvements that could be made [to the service]. They do listen to us. Like I asked for extra training on the hoist, as we don't often use it, and it was arranged".

People across the whole service were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said, "The food is good, excellent. Today we had roast pork with all the trimmings. It was very, very nice and plenty of it". Another person told us, "The food is very good here, it always has been. You get a choice too. If there is something you don't like you can tell them. There is always an alternative". They added "They are generous with the portions or you can have less if you want". A family member told us the food "is lovely".

The chefs who prepared people's food in the residential part of the service were aware of people's likes and dislikes, allergies and preferences. The menu was published on a noticeboard daily to inform people of what options were available. These included a main meal, a light choice and a vegetarian option. People could also have an alternative, such as a jacket potato, salads or steamed fish if they didn't want what was on the menu. People were also offered a choice about the size of the meal they preferred, small, medium or large.

Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. People were not rushed to eat their

meals and we observed lots of laughter and chatting between people sat at the tables. During the meal staff checked with people that their food was okay and checked whether they would like any extra helpings.

Staff were aware of people's needs and offered support when appropriate. For example one member of staff observed a person who was struggling to cut up their meal. They checked with the person "Can I help you with that" to which the person agreed. The member of staff then sat and supported the person while engaging them in conversation about a recent birthday celebration". Drinks, snacks and fresh fruit were offered to people throughout the day.

People who were being supported in their own homes were verbally encouraged to eat and drink enough. Procedures were in place to record people's intake if they were at risk of malnutrition and dehydration, but nobody was considered at risk currently. In most cases, people's meals were prepared by family members and staff had very little input. The goal for one person was to be able to make their own lunch and staff supported them to achieve this.

People across the whole of the service were supported to maintain good health and had access to appropriate healthcare services. Their records showed people were referred to specialists when needed. For example, one person was found to have an inflamed leg and were referred to the district nursing service for treatment. Where health professionals were involved in people's care, all appointments and the outcomes were recorded in detail. One person told us, "If I need a doctor that will be arranged".

A health professional, who had regular contact with the service, told us they had a positive working relationship with staff which benefited people. Another health professional said that staff followed their instructions "to the letter".

Good

Is the service caring?

Our findings

Staff across the whole service developed caring and positive relationships with people. One person told us that the staff were "More than caring, they do more than one hundred per cent from what they should be doing". Another person, who was sat in the garden said, "The staff are very caring. Since lunch [approximately 15 minutes earlier] I have had two [members of staff] come out to see me and check I am alright and not too hot". They added "The staff are fantastic; the whole place is brilliant. The staff are like my brothers and sisters. They treat me well". Other comments from people included, "The staff are lovely. They make you feel relaxed; they put you at your ease", "I see four staff and have got to know them well" and "They are kind and nice". Family members told us they did not have any concerns over how their loved ones were cared for. Their comments included, "I like their caring attitude. They were very cheerful as well", "They didn't intrude in any way; they respected our privacy" and "I enjoyed having [the staff] here and [my relative] looked forward to them coming; they made him happy". Health professionals told us staff were caring and supportive of people living in the home.

People across the service were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. One member of staff who was supporting a person in a wheelchair sat at a table to mobilise; they gently informed them that they were about to "pull the chair backwards a bit so I can put your feet up [on the footplates]. Is that okay"? They patiently supported them, moving their chair gently until they were able to assist them in placing the feet on the footplates. Staff were attentive to people and checked whether they required any support. For example, another person was sat at the table after lunch. A member of staff checked with the person whether they had finished their meal and whether they would like to move to a different location. They said they had and that they would like to leave the table. The member of staff then supported the person to mobilise from their chair to their wheelchair before asking them where they would you like to go.

Staff across the service understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. A member of staff said, "I always ask what people want and how they want us to do it. For example, if I'm washing them I ask if they want me to start at the top or bottom. When I dry them I ask if they like to be dried gently, by patting, or by a good hard rub". Arrangements were in place to check whether people were happy to receive personal care from male or female care staff and their wishes were respected. However, for those people who were being supported in their own homes there was limited opportunity for them to receive care from male only staff. People were offered choices in line with their care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected.

Personal care across the service was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. One person said, "They [staff] know me. They will cover me with towels, they will shut the door". Another person told us that staff respected their privacy and dignity by "Keeping the door shut [when supporting them with personal care], they always ask you, they are so friendly here". A family member told us that staff were "Friendly, caring people" and added "Staff tap on the door

even when it is open. They treat [people] with respect". A member of staff said, "I respect people's privacy at all times. If I'm helping someone to wash, I never undress them completely; I keep them covered up as much as I can and offer them to use the bathroom on their own". Another member of staff told us that when they were providing personal care, "we ask them first, we shut the door, blinds get pulled, we ask if they want family present or not".

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. A senior staff member said, "The plan of support is developed through talking with the client and their family".

People across the whole service were encouraged to be as independent as possible. Care plans encouraged staff to promote people's independence. For example, one care plan instructed staff to put toothpaste on the person's toothbrush and then hand it to them as they could manage to brush their teeth independently. The care plan for another person stated, '[Name of person] is able to wash herself if everything is put ready for her, water in the sink, flannel and towels to hand and a chair so (name of person) can sit when washing herself'. A member of staff told us, "We go and ask [people] if they can walk a few steps or want to use their Zimmer frame, ask them what they want to wear, if they want to drink, what time they want the meal". Another member of staff said, "I see my role as helping people do things they've been able to do before, but may have had their confidence knocked. It's about doing as little as possible and encouraging them to be independent". We observed another member of staff supporting a person to mobilise out of a chair to a walking frame. They encouraged the person to push down on the arms of the chair to stand by themselves, placing a hand gently on the person's back to provide reassurance and support. Staff praised people's efforts and we saw their faces, which reflected a sense of achievement.

People across the service were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. All of people and families we spoke with confirmed that the registered manager and staff supported people to maintain their relationships. One person told us, "I have a phone in my room. My son can phone me and I can keep in touch with him". Another person said, "My husband visits me regularly. He can come when he wants". A family member told us, "I can visit whenever I choose and staff respect our privacy when we are chatting".

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information, which was kept on the computer was also secure and password protected.

Good

Is the service responsive?

Our findings

People and their families across the whole service told us they felt the staff were responsive to their needs. One person said, "When I was in hospital I said to the doctors the only way for me to get better is to send me to the Gouldings. I have been here two weeks and love it here. I would live here all the time if I could". Another person told us, "You couldn't wish for a better place, you have everything you need here, nothing is too much trouble for them. I would definitely recommend this place to other people, I feel like being home, very comfortable". Other comments from people included, "They do what I need, as I like it". and "I'm happy the reablement plan will get me back on my feet within the six weeks". A family member said, "Staff understand [my relative's] needs. She wouldn't come here if they didn't".

Staff across the whole service were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. One member of staff said, "One person struggles to communicate [with us] so we use family members to help with this. Another person's speech is very slurred, so we have to be patient and listen carefully to what they say".

People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's, understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. They also included specific individual information to ensure medical needs were responded to in a timely way.

Staff supporting people in their own homes understood people's needs, their goals and how these should be achieved. They were clear that the purpose of the service was to support people to regain their confidence and develop essential life skills. However, care plans for people in their own homes did not always support the delivery of care or specify the support needed to achieve the identified goals. The registered manager and senior staff told us staff were trained to know how to support people to achieve their goals and agreed to explore how the care plans could be developed to include more information about this to help ensure consistency of care delivery.

Staff took care to treat people as individuals and tailor their approach according to each person's preferences. Comments from staff included: "Everyone is unique in their own way." and "[People] may have similar care plans, but everyone is different and that varies the way things are done".

In the residential part of the service, care plans and related risk assessments were reviewed at the start of each period of respite to ensure they reflected people's changing needs. The care delivered to people living in their own homes was reviewed on a weekly basis with the assistant manager, the team leader and office staff to monitor and assess the progress each person was making towards their goals and to identify any changes that were needed. The person would have already contributed to this review through the team leader. Reviews usually resulted in the gradual withdrawal of support, which tapered off to coincide with the

six week point. Occasionally, the review identified that a person needed more support than they were receiving and this was arranged.

People across the whole of the service received care and treatment that was personalised and they or their relatives were involved in identifying their needs and how these would be met. People had signed their care plans to confirm they had been involved in the planning process. One person told us, "I was involved [in planning my care] but staff know me very well". Another person said, "Yes, I was involved in filling out my care plan. When I arrive, each time I come they ask me the same questions more or less in case something has changed". A third person told us, "When I come in they [staff] go through everything with me and ask if anything has change". A member of staff said, "When they [people] first come in I meet them, introduce myself, we discuss their needs. I also get feedback and if I have concerns I act upon them".

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required with their meals and when mobilising. This corresponded to information within the person's care plan. Handover meetings were held at the start of every shift, in the residential part of the service, which was supported by a communication book. These handovers provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

Staff in the residential part of the service were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. People had access to activities that were important to them. One person's care plan stated '[Named person] likes to sit in the main lounge with other clients as she enjoys chatting and to join in with the daily activities'. One person told us, "We have lots of activities. There is a good crowd in here. Every day we have a sing song". A family member said, "There is always something going on. Some form of entertainment, singing or some other activity. People I speak with are always positive about coming here". Where people did not want to engage in group activities staff interacted with them on a one to one basis. People supported in their own home were encouraged to engage in activities that helped to maintain their independence and life skills.

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. The registered manager sought feedback from people staying in the residential part of the service on an informal basis when they met with them at the home or during telephone contact. One person told us, "Staff ask me if I am happy all the time. If you are not happy you have only got to say and they sort it out". They added "I have always found this a very happy place".

The registered manager also sought formal feedback through the use of quality assurance survey questionnaires. These were completed by people using the residential part of the service at the end of each period of respite and by people supported in their own homes when they were discharged from the service. One person told us, "You fill a form in before you go away. I always give them top marks". All of the comments in the feedback forms we viewed were positive. These included, 'I would like to thank everyone for the care and kindness I received', 'I came here to convalesce after my operation. I couldn't have been cared for any better anywhere else', 'Very pleased with all the ladies. They came on time and gave my wife peace of mind when she was away' and 'All the care staff that have been in to assist me have been very helpful and encourage me to do what I can for myself. It's been a great service; I've no complaints at all'. Where people made suggestions for improving the service, such the need for new televisions in people's rooms, these were responded to and we saw the televisions had been upgraded.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. All of the people and family members we spoke with knew how to complain but told us they had never needed to. One person said, "If I wasn't happy I would complain to the office but I have never needed to. If there was something though I wouldn't be put off complaining. They are all good listeners". The registered manager told us they had not received any complaints since the home was last inspected and was able to explain the action that would be taken to investigate a complaint if one was received. They explained that minor concerns in the residential part of the service would be dealt with informally and if the person still wasn't satisfied they would record it as a formal complaint and follow the provider's complaints process. In addition, for people supported in their own homes there was a 'log of issues', which included accidents, incidents and minor complaints. These were reviewed by managers to identify any lessons that could be learnt.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led and they would recommend the service to their families and friends. One person told us the residential part of the service was "definitely well-led. You often see the manager walking around and talking to people". They added "My biggest problem is I have lost my confidence since I had a fall [at home]. They [the management team] have put everything in place to help me and I am starting to feel better now". A family member said, "When I visit it always appears well run, clean and well staffed". Health professionals told us they did not have any concerns over the management of the home. A health professional said, "They are very open, very supportive, very friendly and always welcoming you. As you walk through the door you already feel part of the team straight away".

There was a clear management structure, which consisted of a registered manager, assistant managers with specific responsibility for either the residential part of the service or supporting people in their own homes, senior staff and the group manager for short term services. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One senior member of staff told us they felt "engaged in the running of the home. We have regular staff meetings, [the registered manager] keeps us up to date and he does listen". Another senior staff member said they had suggested a change in their working hours to make the best use of the time available. This had been agreed, which had been of benefit to people. They said, "It gives me more time to spend with clients". A different staff member told us, "We have team meetings once or twice a year and you get to air your views. For example, we had an issue with the pool cars as they were going to change the pick-up location. We weren't happy, so they changed it."

The provider was fully engaged in running the service, through the involvement of the group manager who reinforced their vision and values. These were built around supporting people as individuals to enable then to regain their confidence, life skills, help reduce the risk of isolation and provide support to their families. Care staff were aware of the provider's vision and values and how they related to their work. One senior member of staff told us, "The interview, the induction and all associated training reinforces to staff that the aim is to re-able people. We monitor and encourage this approach through one to ones and direct supervision".

The frequency of staff meetings varied between the residential part and the team supporting people in their own homes. However, staff told us there were sufficient meetings to provide the opportunity for the management team to engage with staff. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed.

People and family members told us they were given the opportunity to provide feedback about the culture and development of the service. People and family members using the residential services all said they were happy with the service provided. However, people being supported in their own homes raised concerns over the timeliness of their calls and an agreement that visits could be up to two hours before or after the

specified time. Whilst some people said staff usually came at the same time each day "within 10 minutes either way", other people felt the timing of the visits was too wide and was not acceptable. For example one person told us, "They come too early. They're supposed to help me with cooking, but they come at 11:30; I don't want to start cooking then. I mentioned it and they say there's nothing they can do". We raised this with the management team who told us they would look at the concerns but people had agreed to the service knowing this flexible approach was part of that agreement.

The provider had suitable arrangements in place to support the home's management team, through the group manager for short term services. The registered manager told us they felt supported as a result of regular meetings with the group manager, which also formed part of their quality assurance process. They were also able to raise concerns and discuss issues with the registered managers of the other services owned by the provider if they had any concerns.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The registered manager carried out regular audits which included infection control, the cleanliness of the home, medicines management and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, health and safety and fire safety. Some of these checks were carried out by external professionals. The registered manager also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

The care records for people supported in their own home were checked by team leaders and managers when they visited the person, to help ensure staff were delivering care and support in an appropriate way. In addition, when care packages had been completed, the notes and records were returned to the office, where they were audited by one of the assistant managers.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The registered manager was responsive to the concerns and suggestions raised by the inspection team during the inspection. The rating from the previous inspection report was displayed in the reception area and on the provider's website.