Stockport, East Cheshire, High Peak, Urmston & District Cerebral Palsy Society

Cheddle Lodge

Inspection report

29 Ashfield Road
Cheadle
Stockport
Greater Manchester
SK8 1BB

Tel: 01614285189
Website: www.stockportcp.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection of Cheddle Lodge on 29 April 2016. We last inspected the home in November 2013. At that inspection, we found the service was meeting all the regulations that we reviewed.

Cheddle Lodge is registered to provide accommodation for thirteen residents who require support and care with their daily living. At the time of our inspection the home was fully occupied. The home is a single story building situated in a residential area of Cheadle in Stockport. Care staff are available twenty-four hours a day to provide support and ensure the safety and well-being of the residents. All the residents have physical needs and some have learning disabilities. Cheddle Lodge is situated in its own grounds with a garden and small car park to the rear of the building.

The home had a manager registered with the Care Quality Commission (CQC) who was present on the day of the inspection. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

We found one breach of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014, and we have made two additional recommendations.

The home had a supervision policy which recommended staff receive a formal supervision every two months, but we found that this policy had not been adhered to, and some staff had not had a formal supervision from their line manager for over three years. This meant that staff were not receiving the appropriate support to enable them to carry out their duties effectively.
The home did not formally seek feedback from residents or their relatives about the quality of service provision.

When we looked at the complaints procedure we saw that this was written in a format which many of the residents may not be able to understand. We made a recommendation that this is reviewed and a separate complaints leaflet be produced so residents would be able to better understand how to make a complaint.

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

We saw that Cheddle Lodge was clean and well maintained, and all rooms were fitted with tracking rails to assist with safe transfers into and out of beds and seats. Access to the building was secure and staff understood how to protect the residents from different forms of abuse. The service had whistleblowing and safeguarding policies and staff was aware of their responsibilities to report any untoward behaviour they might witness.

Residents were supported by a stable staff team who had worked together for a number of years and knew the residents well. We saw that there were enough staff and people told us that the staffing ratio reflected the needs of the residents.

Care records gave a good indication of resident's abilities and provided a good description of their likes and dislikes. Where risk had been identified, risk plans were in place to minimise the risk of harm occurring. The staff were trained to administer medicines and we saw residents were assisted to take their prescribed medicines in a way they were comfortable with by staff who understood their needs.

The visitors we spoke to told us they believed the staff were competent and knowledgeable. We saw from training records that all new starters received a thorough induction and ongoing refresher training to maintain their competence. The service also provided bespoke training to assist staff to meet the identified needs of residents who lived at Cheddle Lodge, such as epilepsy training or training in supporting residents with swallowing difficulties.

Staff communicated well with each other and we saw that information was exchanged between staff informally throughout the working day, and a detailed handover meeting took place at the start and finish of every shift. This ensured that care staff were aware of any change in need and of any tasks which might need to be completed.

The registered manager and the care staff we spoke to demonstrated a good understanding of capacity and consent. When residents were being deprived of their liberty the correct processes had been followed to ensure that this was done within the current legislation.

Attention was paid to resident's diet and residents were supported to eat and drink in a way that met their needs. We were told that the food was good and that they had enough to eat and drink.
Care staff at Cheddle Lodge monitored residents' general health, and where specific healthcare needs were identified the service was proactive in seeking the right level of support; liaising with health care professionals to provide an appropriate level of support.

We saw residents were comfortable and well cared for. Staff were vigilant to residents' needs and were able to respond in a timely way to requests for assistance. All residents had difficulty with speech but staff had learnt to understand and interpret what they were saying without being presumptuous. They respected needs need for privacy, but understood the risk of social isolation and did not leave residents unattended. Staff spent time talking with residents on a one to one basis or in small groups so that residents felt like they were included. A volunteer who was visiting the service said to us: "Residents have a life here…all the staff are looking for ways to engage with them". We saw, and residents indicated to us, that they were happy living at Cheddle Lodge.

We saw that residents were encouraged to maintain hobbies and interests, and were supported if they wanted to go on holiday.
Relatives informed us that they were listened to, and felt comfortable speaking to any of the staff if they had any concerns.

The home had a registered manager who was respected by staff, residents and their relatives, and had a visible presence throughout the home.

To help ensure that residents received safe and effective care, systems were in place to monitor the quality of the service provided and there were systems in place for receiving, handling and responding

appropriately to complaints, but these were not available in a written format which residents could understand.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.
Staff understood how to protect residents and other vulnerable people from abuse.
There were enough staff to meet people's needs and people were supported by a stable staff team who knew them well.
A safe system of medicine management was in place.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff did not receive regular supervision or appraisal.
Staff showed an understanding of capacity and consent issues.
Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected.
Attention was paid to what people ate and drank, and care was taken to ensure people were supported with their nutritional needs.
People had good access to healthcare and their physical and mental health needs were monitored by staff.

Is the service caring?

Good

The service was caring.
Staff had an in-depth knowledge and understanding of the needs of the people who lived at Cheddle Lodge and provided care in a patient and friendly manner.
Staff were vigilant to need and were able to respond in a timely way to people's requests for assistance.
Privacy and dignity were respected, and people's spiritual and cultural needs were acknowledged.

Is the service responsive?

Good

The service was responsive.
The service had systems in place for receiving, handling and responding appropriately to complaints, but these were not available in a format readily understood by the people who lived at Cheddle Lodge.
Care records contained detailed information about people and how they liked their care to be delivered.

Where possible, people were encouraged to voice their opinions about the quality of their service, and their views were taken into consideration.
People were encouraged to maintain hobbies and interests.

Is the service well-led?

Good

The service was well led.
The service had a manager registered with the Care Quality Commission (CQC) who was held in high regard by staff and residents.
Systems were in place to assess and monitor the quality of service provision.
The registered manager understood their legal obligation to inform CQC of any incidents that had occurred at the service.

Cheddle Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 April 2016 and was unannounced. The inspection team consisted of one inspector. Before this inspection we reviewed the previous inspection report and notifications that we had received from the service. The provider had also completed and returned their Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we interviewed two residents but due to the complex needs of the residents using the service conversation was difficult. We spoke with two relatives of residents; the registered manager, one senior care staff, four care staff members and two volunteers. We looked around all areas of the home, observed how staff cared for and supported residents, looked at food provision, three residents' care records, two medicine records, two staff records, the staff training plan and records about the management of the home.

Good

Is the service safe?

Our findings

Residents told us that they felt the home was safe. One relative we spoke with had looked at a number of homes before choosing this one and told us, "This place felt right. It felt safe and secure. It was the right decision then and nothing has made me change my mind since". We saw that the home was secure, a large hedge ensured privacy from the road and the entrance was kept locked; to gain entrance visitors had to ring the doorbell and staff would check identity before allowing access. This ensured that unauthorised residents would have difficulty entering the home.

We saw that staff took care with moving residents in wheelchairs, for example before escorting a person from the lounge the care workers carefully checked the wheelchair including brakes and footrests, and transferred the person safely. Once in the chair they checked that the person was comfortable and safe before setting off.

All staff had access to the agency's Safeguarding Adults policy which provided guidance to the staff on their responsibilities to protect vulnerable adults from abuse. Staff told us that they were aware of these procedures and understood how to safeguard residents from different types of potential abuse. Staff we spoke to said they had received training about protecting vulnerable adults from abuse and discussed with us the signs that would alert them to potential abuse and the actions they would take. We saw that where a safeguarding concern had been raised recently, there had been a full enquiry which led to a review of procedures around medicines and food intake. This helped to protect not only the individual concerned but helped to minimise the risk of a similar event reoccurring to any of the residents.

Staff were also aware of the provider's whistleblowing policy. When asked about this, one care worker told us, "I am here for the residents, not for any member of staff. I wouldn't hesitate to say if I saw poor practice". A whistleblowing policy helps to protect residents from improper or poor service delivery, and encourages the informant to report any improper behaviour.

Residents who lived at Cheddle Lodge were supported by an established staff team. We were told that the last member of staff to join the team was recruited more than three years ago. This meant that residents were cared for by staff who knew them well. We looked at the recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of residents. We looked at two staff files. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, a job description, and two references. We saw there was a reference verification process in place. This was to ensure that the references suppled were genuine. Checks had been carried out with the Disclosure and Barring Service (DBS) before the member of staff began work and updated recently. The DBS identifies residents who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. DBS checks had also been made for volunteers who supported the service. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Cheddle Lodge

We saw that there was a good ratio of staff to residents. We looked at the staff roster, which was planned in advance, with little need to seek extra support. We were told that any sickness was generally covered by regular staff, and the agency also had a pool of relief staff, who could be called upon if necessary. Staff were deployed on various shifts throughout the day and two waking staff were on duty overnight. We asked staff if they felt there were sufficient numbers, and they agreed that there were; one person told us that the staffing ratio reflects the needs of the residents, so there were more residents on shift at busier times such as early morning and lunchtime, with extra staff at weekends when residents did not attend college, work or day service facilities.

The care records we looked at showed that risks to residents' health and well-being had been identified. These involved risks such as specific risk areas in the home, mobility, eating and drinking, elimination, nutrition and hydration, communication and hygiene. Where there were risks of developing pressure ulcers due to poor posture or movement these were also identified. We saw that where risk had been identified as high or moderate a corresponding detailed care plan was put into place to help reduce or eliminate the identified risks.

We looked to see how the medicines were managed. We checked the systems for the receipt, storage, administration and disposal of medicines. We also checked the medicine administration records (MARs) of two residents. We found the medicines were stored securely in a locked room and the system in place for the storing and recording of controlled drugs (very strong medicines that may be misused) was safe and managed in accordance with legal requirements.
The MARs we looked at showed that staff accurately documented on the MAR when they had given a medicine. This showed that residents were given their medicines as prescribed; ensuring their health and well-being were protected.

Senior staff were trained to administer medication, and we observed one medication round during our inspection. The senior care worker checked the dosage and that the medicines were for the right person before supporting the person to take their medicine. No one received covert medicine. This is the term used when giving medicine in a disguised form, such as in food or drink when the person does not know that they are taking it, but we saw that one person had their medicines in their food. The carer explained that this was because due to their swallowing difficulties and that they were unable to take their medicine in any other format.

Staff we spoke to understood the importance of infection control measures, such as the use of personal protective equipment e.g. tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and residents using the service from the risk of cross infection during the delivery of care.

We saw that the home followed the national colour coding scheme for cleaning materials to minimise risk of cross contamination. For example, mops and buckets were colour coded so different ones were used in the kitchen areas, bathrooms and laundry areas. The kitchen was clean and well organised with food stored appropriately and fridge and freezer temperatures recorded on a daily basis to ensure that any perishable items were kept at the right temperature.

When we toured the premises we saw that corridors and doorways were wide and free of clutter, with adequate space to safely manoeuvre wheelchairs. Bedrooms and communal areas such as bathrooms, toilets, dining areas and lounges were clean, well lit, and free of any unpleasant odours. We were told that the service employed a domestic assistant four days per week who would tackle most cleaning tasks and night staff would cover other domestic duties including cleaning wheelchairs and other moving equipment.

Bedrooms were clean and well maintained; all were fitted with profiling beds and overhead ceiling tracking hoists. Tracking hoists provide a safe and practical way to help move a person from one surface to another, such as from a chair onto a bed. This assisted with safe moving and transfers. Bathrooms were large and well decorated, and equipped with 'Parker' baths with temperature controls. This type of bath allows for safe transfer into and out of the bath and can be raised or lowered to assist with bathing.

We saw records to show that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home.

We looked at the on-site laundry facilities. The laundry was equipped with an industrial washing machine and a tumble-dryer. A low sink was used for sluicing and this was situated by the only entrance and exit, which meant that once cleaned, clothes would have to be taken past this which increased the risk of infection. Sluicing is where solid waste can be rinsed off soiled clothes or linen prior to putting into the wash. When we spoke to the registered manager about this he informed us that the provider recognised the problems with the laundry, and showed us plans which had been agreed to extend the laundry so that there would be clearer separation for clean and soiled laundry and a separate sluicing facility.

We saw that the service had a business continuity plan in place. This contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures, and we saw records which showed fire checks were carried out on a regular basis. Following the inspection the service provided the inspector with a copy of the service's fire evacuation procedure, which detailed how the home would safely evacuate people in the event of a fire. The procedure was developed in consultation with the Fire Service.

Requires Improvement

Is the service effective?

Our findings

Cheddle Lodge's staff handbook stated that staff should receive supervision every two months as a minimum. Supervision meetings support and help staff to discuss their progress at work and also discuss any learning and development needs they may have, or any personal issues which may affect their work.

The staff we spoke to told us that they had not recently had a formal supervision session. We checked two personnel files and saw one care worker had had three supervision sessions with a registered manager in five years and there were no records of supervision in the second file we looked at. Similarly there was no record of an annual appraisal taking place. A yearly appraisal provides an opportunity for staff to meet with their manager to discuss their progress and consider ways of developing their skills and knowledge over the next twelve months. We asked the registered manager why and he acknowledged that regular supervision had not been carried out, but as a part of a service review supervision would take place on a regular basis. We saw that the registered manager had a good and open professional relationship with staff, and staff told us that they could approach him with any issues as they arose. The registered manager was not confined to the office and supported staff with day to day activities which meant that they could observe practice, provide oversight and on the job supervision and instruction.

Staff also informed us that they felt confident in discussing issues of concern with the registered manager, and that they were supported with both work and personal issues. However, there was no opportunity for formal capability appraisal or for staff to discuss areas of interest and consider personal and professional growth.

This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staff must receive support, professional development, supervision and appraisal to enable them to perform their duties.

When we spoke to visitors they told us that they felt the staff were competent and knowledgeable. The relative of a person who used the service told us, "They are all well trained and really seem to know their stuff, they know what they're doing and they all know [my relative] really well."

We saw staff demonstrate a good understanding of the residents, their likes and dislikes, and how best to work with them. We were told that the staff had worked at the home for a long period of time, so they had got to know the residents very well.

The staff we spoke to told us that when they first started they received a full induction into the service and we saw evidence in the staff files that a full induction had taken place for new starters. The registered manager informed us it was mandatory for all staff to complete the Care Certificate, which is a nationally recognised training qualification to ensure staff provide compassionate safe and high quality care and support.

We saw that the service set clear expectations for the staff and provided on-going training to ensure that

staff had the skills to carry out their role. From the training matrix, which maps out the training staff have completed, we saw that care staff had completed courses in disability awareness, equality and diversity, manual handling, health and safety, first aid, safeguarding vulnerable adults, and food hygiene. Additional training in medication and safe administration of medicine was provided by a local pharmacy, and all staff had been trained to administer medicines.

The provider had arranged specific and bespoke training for staff relating to the identified needs of the residents, for example, dysphagia (swallowing difficulties). One care worker told us that the training they received was very good and tailored to the needs of the residents: "This place is so different to other places, no one had ever told me how to properly put a jumper on, but you learn that here".

Another care worker enthused about some epilepsy training organised by the service: "It was brilliant! The consultant from Hope Hospital explained exactly what epilepsy is. I learnt so much, especially about different types of seizures. It's been really helpful".

We saw that staff communicated well with each other and passed on information in a timely fashion. We were told that 'handover' meetings between the staff were undertaken on every shift. We witnessed one handover meeting during our inspection and observed staff providing an update on each person including information about any issues or concerns. Handovers help to ensure that staff are given an update on a person's condition and behaviour ensuring that any change in their condition is communicated and understood.

The Mental Capacity Act (2005) (MCA) provides a legal framework for making particular decisions on behalf of residents who may lack the mental capacity to do so for themselves. The Act requires that as far as possible residents make their own decisions and are helped to do so when needed. We saw evidence that where decisions needed to be taken on behalf of a person consideration of the least restrictive options were discussed at a best interest meeting and the least restrictive option agreed, for example, with regard to the use of a restraint belt on a person's wheelchair to stop their arms flailing.

Residents can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of any deprivations and report on what we find. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.
The registered manager told us and we saw information to show that eleven applications to deprive residents of their liberty had been submitted to the supervisory body (local authority). Capacity assessments had been completed to determine why residents needed a DoLS authorisation. This helped to make sure that residents who were not able to make decisions for themselves were protected.

We saw examples where care staff would ask for consent before carrying out tasks, for example, when giving out medicine the senior care worker would ask the person if they were ready and when a volunteer began a singing group residents were asked if they would like to participate.

We saw that attention was paid to residents' food and drink and residents had a balanced diet. The kitchen displayed information about allergens and staff understood the specific requirements of the residents. Most were on a regular diet but one person had specific cultural requirements which were met. All the residents were dysphasic. This meant that they had difficulties swallowing and all food served was blended to the consistency recommended by dieticians and Speech and Language therapists (SALT).Two residents had a

Percutaneous endoscopic gastrostomy (PEG). This is a medical procedure in which a tube (PEG tube) is passed into the person's stomach to provide a means of feeding when the person cannot take food orally. All staff had been given training in safe care and use of peg tubes

We saw in case files that residents had an eating and drinking plan which detailed how to prepare their food in accordance with swallowing needs and documented how to support residents to eat whilst ensuring they maintained some independence.

One person we spoke to agreed the food was good and the portion size was ample. The home employed two cooks who had a budget to purchase food. They bought from local suppliers and used the supermarket for general foods. We saw residents had a choice of meals. Breakfast could be hot or cold with cereal, toast, sausage, eggs and bacon available. We observed the lunch time period Residents had pureed beef burger with mashed potato and peas. Most residents required assistance to eat and drink; to ensure residents received the support they needed there were two sittings. Care staff provided assistance on a one to one basis, siting with the person, talking with them, establishing eye contact and helping them to eat and drink at their own pace. The residents who could feed themselves were not overlooked and were drawn in to the conversation. Lunchtime was a sociable, relaxed and happy occasion, with staff engaging well with residents.

Residents had good access to healthcare and their physical and mental health needs were monitored by staff. Weights were regularly checked, and the service had established good working relationships with speech and language therapists to monitor diet and swallowing and seek advice about food consistency. Evidence in the case notes we reviewed showed liaison with District nurses, for example, to monitor skin integrity. Sometimes the complex needs of residents meant close attention to detail, and liaison with a range of medical clinicians. For example, a person with difficulties swallowing, medication needs and continence issues required a careful care plan. The home adopted a co-ordinated approach to meeting this person's needs, liaising with their general practitioner (GP); SALT, pharmacist and incontinence advisor to agree the best way to provide treatment and support. We saw in the diary that residents had regular access to other health care professionals such as dentist, optician and chiropody appointments. This meant that residents were receiving care and support to access additional health care services to meet their specific health needs.

Good

Is the service caring?

Our findings

The service aimed to promote a caring environment. The Registered Manager told us that they had built good relationships between staff and the residents to create an open friendly atmosphere.
Nearly everyone we spoke to talked of Cheddle Lodge as 'family'. For example, one relative said, "It's fantastic; friendly and homely. We made the right choice coming here; it's very caring. I feel [my relative] has got a new family and is happy and settled". A care worker said "Its family. You are like a family to them; I get quite defensive when I'm talking about them".

Many of the residents had grown up together. We were told that the service began as a school for children with cerebral palsy and then the service provided day care before opening Cheddle Lodge as a residential facility twenty-eight years ago. Six of the residents had lived there since it opened. The staff team had also remained constant; the registered manager told us he had been there for thirteen years and some of the staff were there when he arrived.

The complex needs of residents meant it was difficult for them to communicate with us but one person told us that the staff "know me, and look after me. All the staff are good to me". Another person indicated that he was "extremely" happy with the care he received.

Cheddle Lodge had a comfortable and calm atmosphere and we observed respectful and caring interactions between care staff and residents. Staff were vigilant to residents' comfort and checked on them regularly. Residents were not left for too long in the same chair or position and were transferred using the proper equipment and safe moving and handling techniques. We saw one care worker checking a person who used the service, who indicated that he was tired. The care worker reiterated his wishes and asked if he would like to go for a lie down.

Staff knew and understood the residents. All of the residents had difficulty with speech but staff had learnt to understand them, interpret their words and reiterate their requests. For example, we saw one person indicated a need using sounds and gestures. The care worker paraphrased to check that they understood the request, which was to go and sit closer to the window so that they could look out onto the garden. The person agreed that this was his wish, and the care worker helped the person safely into their wheelchair before taking them to where they wanted to be.

We saw that staff spent time with residents either on a one to one basis or in small groups; care staff found time to sit and talk to residents so they were not left on their own. Privacy was respected; in addition to the main lounge Cheddle Lodge had a separate 'sun lounge' which was used for activities or quiet time for residents. Each person had their own bedroom with fitted furniture chosen in consultation with the person, decorated well and personalised with the person's residents own furniture, ornaments and belongings according to their preference.

The care staff we spoke with had a good understanding of the importance of treating residents as individuals. We saw that residents were treated with dignity and respect and offered choice in the delivery of

their care and support. They were addressed by their preferred names and spoken to in a friendly manner making eye contact and touch, where appropriate.
A discussion with the registered manager showed they were aware of how to access advocates for residents, and we were told that one person who used the service had chosen an advocate to speak on their behalf. An advocate is a person who represents residents independently of any government body. They are able to assist residents in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

We were told the cultural and religious backgrounds of residents were always respected, and we saw from training records that staff had received training in equality and diversity issues.

We saw that care records were kept secure in the staff office, and when we spoke to staff, they understood importance of ensuring confidentiality of information was maintained.

Good

Is the service responsive?

Our findings

Residents indicated to us that staff responded to their needs and provided them with support when they required it. One visitor told us about their relative: "He is happy with Cheddle Lodge. The staff have got to know him and it's all about him". A volunteer said to us "[Residents] have a life here. It's wonderful. All the time the staff are looking for ways to engage with them. One never gets the impression anyone is being ignored. It's about residents living together and they make a life".

We looked at three care records. Information about each person was detailed and written in a person centred way focussing on their abilities and strengths. Information provided gave a good indication of the person's character and personality, for example, in one record we saw that the person liked to have, "Residents around him with a good sense of humour, but no comedians". The care records contained detailed information to guide staff on the care and support to be provided. They also showed that risks to residents' health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted action to reduce or eliminate any identified risk was recorded in detail. We saw that specific specialist information and guidance from the relevant professionals involved in their care was contained within the care records. The records were reviewed regularly by staff to ensure the information was fully reflective of the person's current support needs.

Care plans included reviews which recorded who had been consulted in the review. From our observations and discussions with the registered manager and staff it was apparent that the most of the residents did not have the capacity to be involved in the planning of their care. Where residents did have a greater understanding of their needs and how they could be best met, they were encouraged to voice their opinions. One person we spoke with agreed that they had been involved in reviewing how their care was delivered. When we spoke to relatives of residents they told us that they were kept informed of residents' needs and their views were sought. One relative told us, "I have been involved in planning meetings and best interest meetings. I have been to some, but if it's about technical things I leave it to the experts".

During our inspection some of the residents went out to day service activities organised by the provider, and one person was at college. A volunteer conducted a 'sing-along' session during our inspection which appeared to be popular with the residents who had remained at Cheddle Lodge. The service did not employ an activities co-ordinator but all staff would spend time with residents and helped to create a stimulating environment. We saw that residents were supported to pursue their hobbies and interest, for example, one person was a keen supporter of Manchester City, and was encouraged and assisted to attend home matches.

A relative told us that their relative was regularly invited to events and would go on day trips. They also informed us that birthdays were made into an occasion to be celebrated.
The registered manager informed us that all the residents used to go on holiday together, but this practice had stopped due to limited resources. However, if residents wished to go away, they were encouraged to do so, and were supported by staff. The service had a mobile hoist which they could take with them. We saw plans were being developed for one person who used the service to go to France to celebrate their 65th

birthday.

A service user guide given to all residents with a copy in their care files explained how to make a complaint, to whom and how it would be dealt with. However, we saw that this had not been produced in an easy read format which would make it more accessible to residents.

We would recommend that the service reviews its complaints procedure to make it available to residents in a format that they can understand.

We looked at the complaints log and saw that there were no outstanding complaints and any received had been appropriately dealt with. We spoke with a relative who informed us that they had made a complaint, but stated that they felt comfortable with raising the issue and believed that they were listened to, and felt that the service had learned from the incident raised to improve how they supported the person who used the service.

Good

Is the service well-led?

Our findings

All the people we spoke to emphasised the homely nature of Cheddle Lodge, and promoted the view that this was where people lived
Cheddle Lodge promoted a homely and family environment. A relative we spoke to told us that their relative "has settled here. I brought [my relative] back to my home for a couple of days, and when we came back to Cheddle Lodge she looked at me as if to say 'Thank goodness I'm back!' This is her home". One care worker said to us "They are residents here, not service users. This is their home and we respect that". A volunteer told us "Everyone who lives here has a disability but you don't see that. You just see the person". The positive culture of the service was reflected in the interactions we observed to encourage individuals and listen to them as well as providing support; as one care worker said, "residents say what a fantastic place this is, it's so nice and the residents are so at ease. Residents sit around tables together - staff and residents - and they are all involved. It's not just one family with staff but family for them. They've grown together and are protective around each other". Cheddle Lodge was a stable community. The majority of the residents had known each other most of their lives and had lived at Cheddle Lodge for a long time. New residents had been warmly welcomed.

We saw staff were highly motivated and worked together as a team, and the residents were supported by trained staff who understood the needs and wishes of residents. The staff we had discussions with spoke positively about working at the home. One care worker told us that they looked forward to coming in to work and believed that stability was key to the success of the home: "Working alongside people we know and trust, for people we know and get on with makes all the difference. Everyone gets on, and we all get on with our jobs".

We saw that, where possible, residents were involved in decision making, for example, we were informed that when new staff are recruited the residents assist in choosing the candidate, and residents' had been consulted about any changes in the decoration of the building

We saw that resident meetings were held. Although the service acknowledged the difficulties in communication, the staff's familiarity and knowledge of the residents helped them to understand, interpret and paraphrase their views. These meetings gave staff an opportunity to feed back to all residents any actions that affected the service and allow for consideration of their views.

The relatives of residents we spoke to told us that they were kept informed of any changes in their relative's condition and felt comfortable about contacting the service. They told us, and we saw minutes to show that they attended relatives meetings and were kept informed of any changes to the service or any new developments. This also gave them an opportunity to air any collective concerns about Cheddle Lodge. However, the registered manager informed us that he does not conduct any surveys or questionnaires about the service and that there was no formal system to seek feedback or collate the opinions of residents living at Cheddle Lodge or their relatives. Such a system could be used to inform improvement plans for the development of the service.

We would recommend that the service considers a method of seeking formal feedback from people who use the service, their relatives and other stakeholders in order to evaluate and improve practice and service delivery.
It is a requirement under The Health and Social Care Act that the manager of a service like Cheddle Lodge is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since February 2011. The registered manager was present throughout the inspection.

Everyone we spoke to held the registered manager in high regard. A volunteer told us the registered manager: "Is very compassionate and kind. He understands needs and what people need as well as what makes them tick, and that's staff and residents". A care worker made similar comments and added, "He listens to our concerns and spends time listening to what the residents say. If something is needed, he will get it done. He respects you for who you are, but knows how to crack the whip". When we asked residents, they agreed that he was a "good and caring" manager.
Care staff told us, and we saw, the registered manager was visible around the home every day when they were on duty. He showed a clear understanding of his role and responsibilities and was aware of his responsibility to pass on any concerns about the care being provided to the registered providers, local authority and health commissioning teams, safeguarding team and CQC as appropriate.

The registered manager told us he is supported by the provider, Stockport and District Cerebral Palsy Society, who will meet any reasonable requests for additional resources, for example, provision to redesign and update the laundry facilities.

We asked the registered manager to tell us what systems were in place to monitor the quality of the service to ensure residents received safe and effective care. We were told that the Chief Executive of the service would visit on a monthly basis and conduct an internal inspection and regular audits/checks were undertaken on all aspects of the running of the service. The registered manager completed internal reports for the provider on a regular basis. Reports covered, staffing, training, resident issues, audits of reviews and care plans, and activities.

We also saw that the service had responded to constructive criticism; a quality assurance visit from the local authority recommended a review of care records. We saw that this had been acknowledged and the registered manager had completed a full review of the methods used to store information, and all care records had been reviewed and re-written. Within the new system were plans to complete a full audit of case files on a monthly basis. This would ensure that all information stored was relevant and up to date.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross-referenced to new regulations.

Before our inspection, we checked with the local authority commissioning team and safeguarding team, and they informed us that they did not have any concerns about Cheddle Lodge.

The registered manager was aware of when notifications had to be sent to CQC and had notified us of required incidents. This demonstrated the registered manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing staff did not receive formal supervision on a regular basis. Regulation 18 (2) (a)