Care Quality Commission

Appletree House Residential Care Home Limited

Apple Tree House Residential Care Home Limited

Inspection report

31 Norwood
Beverley
Humberside
HU17 9HN

Tel: 01482873615

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27 January 2017

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 27 January 2017 and was unannounced. The previous inspection was undertaken on 22 September 2015 and at that time we rated the home as Requires Improvement in the areas of Safe, Effective, Responsive and Well-led. We made a requirement in respect of Regulation 12: Safe care and treatment. This was because there was no effective system in place to identify medicine inaccuracies. We made a requirement in respect of Regulation 13: Safeguarding service users from abuse and improper treatment. This was because the registered provider had not acted in accordance with the MCA in respect of there being no authorisations in place for people who had been deprived of their liberty. We made a requirement in respect of Regulation 17: Good governance. This was because there was no effective system in place to assess, monitor and improve the quality and safety of the service. We also recommended that the registered provider ensured care records were reflective of people's needs, reviewed regularly and that people's consent to their care was obtained.

On the day of this inspection we found that the registered provider had taken action to improve practices within the service following the inspection in September 2015. We found these improvements were sufficient to meet the requirements of Regulation 12, 13 and 17. This meant the service had met the breaches of regulation

The home is registered to provide accommodation for up to 12 people who have a learning disability. On the day of the inspection there were 12 people living at the home. The home is situated in Beverley, in the East Riding of Yorkshire. It is close to town centre facilities and transport links. The accommodation in the main building is on two floors and people who are accommodated on the first floor are able to use the stairs independently. There are also three bungalows in the grounds and these are for single occupancy. There is one flat that is accessed via external stairs and the person who lives in the flat is able to manage the stairs. The people who live in the flat and the bungalows can choose whether to have their meals and spend time in their own space or in the main building. Other accommodation includes a lounge, a dining room, a kitchen and an additional room that is used by people who live at the home and staff for a variety of activities. There is an enclosed courtyard garden.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was registered on 14 September 2015 and they had previously managed other care services.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. This included supporting people to take part in their chosen activities. New staff had been employed following the home's recruitment and selection policies and this ensured that only people

considered suitable to work with vulnerable people were working at the home.

People told us they felt safe living at the home. Relatives also told us they felt their family members were safe living at the home and this view was supported by a health care professional who we received feedback from. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. There were effective systems in place to manage any safeguarding concerns.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. Medicines were administered safely, and staff had received appropriate training on the administration of medicines.

Relatives and a health care professional told us that staff were caring and people's privacy and dignity was respected. We saw very positive interactions between people who lived at the home and staff on the day of the inspection.

People's nutritional needs had been assessed and were known by staff. People had a choice of meals to meet their individual requirements.

We saw that any complaints made to the home had been thoroughly investigated and that people had been provided with details of the investigation and outcome. There were also systems in place to seek feedback from people who lived at the home, relatives, staff and health care professionals about the quality of the service provided.

Staff, relatives and a health care professional told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote the well-being of people who lived at the home.

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 adhered to the home's medicines policies and procedures and this meant people who lived at the home received their medicines as prescribed.

There were sufficient numbers of staff employed to ensure people received a safe and effective service. Staff had been recruited following the home's policies and procedures.

Staff had received training on safeguarding adults from abuse and they were aware of how to refer any concerns to the appropriate organisations.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and we observed that different meals were prepared to meet people's individual nutritional needs.

People had access to and support from health care professionals when required.

Is the service caring?

Good

The service was caring.

We saw positive relationships between people who lived at the home and staff. Relatives and a health care professional told us that staff were caring and were skilled at communicating with people.

Staff respected people's privacy and dignity, and it was clear that

people's individual care and support needs were understood by staff.

People were informed about advocacy services should they need to use them.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests, the people who were important to them and their preferences and wishes for care.

People were encouraged to take part in meaningful activities and contact with family and friends was encouraged and supported.

There was a complaints procedure in place and people told us who they would speak to if they had any concerns or wished to make a complaint.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed.

There were sufficient opportunities for people to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

Care Quality Commission

Apple Tree House Residential Care Home Limited

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.

The inspection took place on 27 January 2017 and was unannounced. One adult social care (ASC) inspector carried out the inspection.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider and information we had received from the local authorities who commissioned a service from the registered provider. We also requested feedback from a number of health care professionals, and received information from one. The registered provider was asked to submit a provider information return (PIR) prior to this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned within the required timescale.

On the day of the inspection we spoke with five people who lived at the home, two relatives, two members of staff and the registered manager. We looked around communal areas of the home and bedrooms, with people's permission. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Following the day of the inspection we spoke with the relative of one person who lived at the home to gain their feedback.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "Yes, the building is safe and staff make me feel safe" and another told us, "Carers make you feel safe. We tell them if we are going out and we tell them where we're going and what time we'll be back." We asked staff how they kept people safe and they told us, "We are aware and are watching all the time. Training makes you more aware" and "We have risk assessments that all staff are expected to read."

A health care professional confirmed they felt people who lived at the home were safe. They told us, "On arrival staff have always checked my identification and guided me to the sign in book. On leaving staff have always made sure I have signed out and have escorted me to the door." Relatives also told us they felt people were safe.

Identification forms had been produced in case people absconded from the home. Most people were able to use the call bell in their private accommodation by pulling the cord. One person could not use the call bell and they activated the alarm by using special equipment worn on their wrist. Staff carried out two hourly checks when people were in their own accommodation to make sure they were safe.

We noted that moving and handling plans recorded the level of assistance the person required. These plans provided staff with the advice they needed to safely assist people to mobilise around the home and in the local community.

The registered manager had attended safeguarding 'threshold' training provided by the local authority. This included a monitoring system for managers to help them identify which incidents required managing in-house, and which incidents needed to be reported to the local authority safeguarding adult's team. We checked information in the safeguarding folder and saw that there had been five incidents during 2016. These had been thoroughly recorded and alerts submitted to the local authority as required.

There was a policy and procedure in place on safeguarding adults from abuse. The staff we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we looked at. Staff were able to describe different types of abuse and the action they would take if they became aware of an incident of abuse or had any concerns. One member of staff told us, "I am certain the registered manager would take the appropriate action."

We reviewed the records of accidents and incidents for both staff and people who lived at the home. People had body maps in place to record any injuries or bruises / sore areas; this helped staff to monitor the person's recovery. We noted that a quarterly summary had been completed and that this enabled the registered manager to check for areas that required improvement, and to identify whether any patterns were emerging.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for using a kettle, cycling, the use of wheelchairs and foot plates, meal time support,

medication and vulnerability to abuse.

People had a secure cabinet in their room to store their medicines. The temperature of these cabinets was recorded daily to ensure that medicines were stored at the correct temperature. Medication administration records (MARs) for everyone who lived at the home were held in one folder. MARs are forms that are specifically designed to record the daily administration of medicines. MARs were supported by an information sheet that recorded details of the persons GP, room number, any known allergies and details of any homely remedies they took.

There were suitable storage and recording arrangements in place for the management of controlled drugs (CDs). CDs are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We checked a sample of CDs held and records in the CD book and saw that these balanced.

There was an audit trail to ensure that medicine prescribed by the person's GP was the same as the medicine provided by the pharmacy. There were robust arrangements in place to record medicines for people when they were on 'home leave' or attending a day centre. The arrangements for returning unused medicines to the pharmacy were satisfactory.

Team leaders were responsible for medicines management but all care staff had completed training on the administration of medicines. The training records we looked at confirmed this. We also saw that, when staff were new in post, their practice was observed on several occasions before they were deemed safe to administer medicines unsupervised. Regular audits of medicines were carried out to check that people had received the correct medicines at the correct time, and that the records of administration were accurate.

We checked the recruitment records for two new members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. The employment references that had been received had been verified by the registered manager to confirm they were authentic. We saw that one person's DBS check had arrived after they had commenced work at the home, although they had provided evidence of a recent DBS check with another care provider. The registered manager assured us they would ensure these checks were in place prior to people commencing work at the home in future. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at the home.

We found that this was sufficient to meet the needs of people who lived at the home. One relative told us they felt there were enough staff on duty. They said, "They seem to have [enough staff on duty]. When people are poorly they seem to provide the right care." However, another relative told us they felt there were occasions when the home would benefit from having more staff on duty, such as during the night and at weekends. People who lived at the home told us there were enough staff on duty. One person said, "There's always someone around" and another told us, "Yes, there's always enough staff to help me." A member of staff told us there were occasions when more staff would be beneficial, but that staffing levels were generally fine. Staff confirmed that agency staff were not used as existing members of staff were willing to cover any vacant shifts between them.

On the day of the inspection we saw the registered manager, a team leader and two support workers were on duty, plus another support worker who was at the home specifically to support one person. In addition to this, there was a student on work placement working alongside staff. During the night there was one

'waking' and one 'sleeping' member of staff on duty. Staff on duty prepared meals and drinks and there was a domestic assistant who carried out the main cleaning tasks.

We checked the staff rotas and saw that these staffing levels had been consistently maintained. Rotas also evidenced that staffing levels were flexible, as on occasions additional staff were on duty to assist people with attending appointments or social events. For example, there was an additional member of staff on duty on Thursday evenings as some people liked to attend a local youth club, and one person had one to one support when they attended a nearby day centre.

Weekly tests of the fire alarm system were being carried out, which included checks on emergency lighting. Fire drills were taking place to ensure that staff were aware of the action to take in the event of the fire alarm sounding. The last recorded fire drill had been carried out in October 2016 and no areas of concern had been identified.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, the fire alarm system and emergency lighting, portable electrical appliances and fire extinguishers. Personal equipment used by people to assist them to mobilise was serviced by the company who had supplied the equipment.

Any repairs that were required were recorded in the in-house maintenance folder. We noted that there was no record of when most repairs had been carried out. The registered manager told us that these repairs had been carried out in a timely manner and that she would remind the maintenance person that they must sign the maintenance log to record this.

There was a business continuity plan in place that advised staff on the action to take in the event of emergency situations. There was also a personal emergency evacuation plan (PEEP) in place that recorded the support each person would need to evacuate the premises in an emergency, although some PEEPs required more information to be added.

We walked around the home and saw that communal areas, bedrooms, bathrooms and toilets were being maintained in a clean and hygienic condition. Relatives who we spoke with told us the home was always clean. One relative described the home as "Spotless."

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We saw that, when applications to deprive a person of their liberty had been authorised by the local authority, notifications had been sent to CQC as required. We found that the registered manager and staff displayed a good understanding of their roles and responsibilities regarding MCA and DoLS, and promoting people's human rights. In addition to this, staff had received appropriate training on these topics.

Staff told us they did not need to use physical restraint with people who lived at the home. They described how they would use diversionary techniques to manage any behaviours that might challenge the service.

People told us that they consented to their care. They said that staff always checked with them before they assisted them with any tasks. One person told us, "[Staff] ask if it's ok to help. They never just take over." We saw that people had signed consent forms to agree to have their photograph taken and to agree to take part in a research study. One person had signed a document to evidence that they had chosen their own key worker.

Most people who lived at the home were able to make decisions about their lives but required guidance and advice from staff. Staff described to us how they helped some people to make day to day decisions, such as holding out different outfits so people could choose the one they liked. We saw that a best interest decision had been made about fitting a key pad entry system to the front door, and the person's ability to use it. The documents we saw evidenced that this decision making was appropriate.

We observed that staff had the skills they needed to carry out their roles and this was supported by the people we spoke with. Records evidenced that new staff completed a thorough induction and also shadowed experienced staff as part of their induction. Staff told us they could shadow until they felt confident enough to work as part of the staff rota. One member of staff said, "I had thorough induction and shadowed for two weeks even though I had previous experience [in care work]."

The registered manager told us that essential training was health and safety, fire safety, MCA and DoLS, safeguarding adults from abuse, first aid, food hygiene, epilepsy and infection control. We saw that staff had completed this essential training, although refresher training was due on the topic of epilepsy. The registered manager told us that training on epilepsy was booked for 20 February 2017. For most staff this

would be refresher training, but for two new staff this was initial training.

Additional training was available for staff to meet their particular interests or the needs of people who lived at the home. These topics included conflict management, equality and diversity, confidentiality, working with mental health, dignity in care, falls in care homes, record keeping and challenging behaviour. We noted that the training record included the date refresher training was due. Staff told us they completed sufficient training to equip with them with the skills to carry out their roles.

Most staff had completed a National Vocational Qualification (NVQ) award at Level 2 and some were working towards their Level 3 award. The team leaders were working towards this award at Level 5. NVQ was previously the national occupational standard for people who worked in adult social care that has now been replaced by the Qualifications and Credit Framework (QCF).

Staff told us they were well supported and that they had regular supervision meetings. One member of staff added, "But I can speak to [name of registered manager] any time. I don't have to wait for meetings." The records we saw in staff files confirmed that they attended regular supervision meetings. These are occasions when staff meet with their line manager to have a one to one discussion about their training needs, any concerns they may have and to enable them to discuss the people they were supporting.

We saw the staff used a daily 'handover sheet to record the tasks that needed to be completed that day and to share information with the next group of staff on duty. The handover sheet included information about healthcare appointments, the staff on duty, domestic tasks to be completed by staff, food and fridge temperature checks, a reminder about the daily documentation that needed to be completed and information about individual people who used the service, including their food likes and dislikes. This helped to make sure tasks were completed and that all staff were aware of forthcoming appointments and activities.

Meals were prepared by the staff on duty, with assistance from some of the people who lived at the home. We observed that the meals provided were based on people's likes and dislikes and their specific dietary requirements. We noted that one person received a fortified diet as they were very mobile and at risk of losing weight. There was a daily menu on display that included both words and pictures to assist people to understand the choices on offer. Assistance was offered when this was appropriate, and staff chatted to people and encouraged them to eat. This made the mealtime a social experience.

People told us that they enjoyed the meals. Comments included, "The meals are very good. They know my likes and dislikes", "There's plenty of choice. I like everything" and "I love the food." However, one relative told us they felt people should be offered a pudding after the main meal in the evening, not just fruit or yoghurt. This was fed back to the registered manager following the inspection.

Nutritional screening tools had been completed and people were weighed on a regular basis as part of nutritional screening. When there were concerns about people's food and fluid intake, dieticians and speech and language therapists (SALT) had been involved in the person's care. A health care professional had recommended that one person followed a high fat diet and their health had improved, so they had been discharged from the professional's care.

Some people told us they went to the surgery if they needed to see their GP, and other people told us that staff went with them to the surgery. We saw contact with health care professionals was recorded, including the reason for the contact and the outcome. People's records evidenced that advice had been sought from GPs, dentists, the community learning disability team, chiropodists, occupational therapists,

physiotherapists and dieticians, and any advice received had been incorporated into people's care plans. Health care professionals told us that the registered manager and staff asked for advice appropriately and then followed that advice. A health care professional said, "Following assessments, I have provided recommendations to support the service users. These recommendations were discussed with the manager and the staff, then reviewed two weeks later. The staff were able to provide examples of how and when they used the resources and strategies recommended." We saw that any correspondence to and from NHS organisations was retained in people's care plans, and any hospital admissions or appointments were also recorded.

People had patient passports in place. These are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff, or would have difficulty explaining this information clearly. This meant that hospital staff had information to help them support the person appropriately.

Good

Is the service caring?

Our findings

We observed positive relationships between people who lived at the home and staff. Staff were kind, considerate and supportive in the way they interacted with people. People told us they felt staff really cared about them. Two people told us, "Yes, I feel important to them." Staff told us that they felt staff who worked at the home genuinely cared about the people they supported. Comments from staff included, "Yes, without a doubt" and "Staff go 'over and above'."

Relatives told us their experiences led them to believe staff genuinely cared about people who lived at the home. One relative said, "Oh yes, they definitely do." They went on to name three members of staff who they described as 'excellent'. Another relative told us, "Staff genuinely care." However, they added, "They definitely have time for the 'easiest' residents but may need more time for the others."

A health care professional told us that staff were caring. They said, "The staff demonstrate that they care about their service users and show awareness of their individual needs." On the day of the inspection we saw that a team leader came to the home on their day off to take one person, who they were key worker for, to the shops.

Staff explained to us how they respected people's privacy and dignity. One member of staff said, "We ask permission first. We then make sure doors are locked and curtains and windows are closed." A relative told us that staff respected their family member's privacy and dignity, and that their family member had a key to their bedroom so they could lock it if they wished to do so. Although everyone who lived at the home had their own accommodation, a health care professional told us it would be beneficial for there to be a quiet room where private conversations could take place.

Staff told us that people who lived at the home had a wide range of abilities. They said that, if they could do things for themselves such as washing and dressing, they encouraged them to do so. One person told us they were independent with their personal care needs. They said that they asked staff for clean towels but could take a bath or shower themselves. They also told us that they were being supported by staff to move into more independent living accommodation.

Relatives felt their family members were encouraged to be as independent as possible. They said that staff encouraged people to do as much as they could for themselves, and reminded them about certain aspects of their personal care rather than doing these tasks for them.

No-one required the support of an advocate at the time of the inspection. The registered manager was aware of the need to use advocates to assist people with decision making, and the home's statement of purpose informed people that they could have the support of an advocate. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

People who lived at the home told us that staff communicated with them and shared information in a way

they could understand. One person told us that they were told which staff were going to be on duty next, and another said they were well informed about GP appointments and staff rotas. One person said, "We always know what's going on." Relatives told us that they were kept well-informed of events concerning their family member. One relative told us, "We visit quite often but they ring us if there is a problem." When staff had met with people who lived at the home to discuss their health care needs, or to discuss their choice of activities, this had been recorded on a 'consultation report' form.

A newsletter was produced each season. We saw the newsletter for Autumn 2016 and noted that it included a description of Autumn, an introduction to new staff and 'good bye' to staff who were leaving, information about Bonfire Night and a local bonfire event, a fun article about witches and warlocks and a Halloween word search. This helped people to keep up to date with events at the home and in the local community.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We saw that these diverse needs were adequately provided for within the service. The care records we saw evidenced this and the staff we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. An information document included details of the person's family relationships, their GP and any other health or social care professionals involved in the person's care. Care plans included a document called 'All About Me', which included information about the person's life history and their daily routines. People also had health plans in place that recorded their medical history, any known allergies and any specific treatments they required. Some people also had 'epilepsy' care plans in place.

People were aware that they had a care plan in place and relatives told us they had input into their family member's care plan.

We saw that people had behaviour management plans in place that recorded the behaviours that they might display whilst at the home or in the local community and the techniques that should be used by staff to manage these situations. This meant that all staff had access to the same information so that they could support people in a consistent way.

We asked staff how they got to know about people's individual needs. They told us that they read people's care plans and, when they were new in post, they had asked more experienced staff for advice. One member of staff said, "We work with people as they are now. One person doesn't want us to know about their past and some people don't have family members for us to ask." They added that staff worked well as a team and there was good communication in staff handovers so staff were kept aware of people's current care and support needs.

Monthly care plan summaries recorded information about activities / social leave, the person's aims and development and information about medical appointments or interventions. We saw evidence that care plans were reviewed each month to ensure they were up to date, and more formal reviews had been organised by care managers from the local authority to review the person's care package. This meant that the appropriate people were involved in reviewing people's care packages to ensure they continued to meet their needs.

We saw that people received person-centred care. A health care professional told us, "I have observed staff adapt interaction and communication to meet the individual needs of each of their service users, such as ability levels, interests and preferences." Relatives also felt that, if any advice was shared with staff about ways of communicating with their family member, this was 'taken on board' by staff.

Care plans included a record of meetings people had with their key worker. This included details of the activity they had taken part in, the actual time spent participating in the activity and the person's 'mood' during the activity.

People told us they had enough to do to occupy themselves and we saw care plans included people's weekly activity plan. One person attended a day centre on Mondays, Wednesdays and Thursdays. One

person said, "We can go out as long as they [staff] know where we are. Me and [name of other service user] went to the pub on Wednesday to play pool." Another person told us they required support from staff to go out, and that they also paid other care workers privately to support them with activities in the community. The activity board included words and pictures to assist people to understand the activities on offer. On the morning of the inspection we saw that three or four people were doing jigsaws, one person was 'doing paperwork' and two people went to the shops with staff. In the afternoon most people sat in the lounge and watched a DVD. Other people spent time in their own accommodation either carrying out chores or working on the computer.

Relatives told us that people could be encouraged to take part in more activities. One relative said their family member used to play dominoes and might like to try this activity again, and another relative said their family member would like to bake. We fed back this information to the registered manager on the day of the inspection.

People were integrated into the local community. Some people had certificates of achievement in place that they had gained whilst at work or college. One person told us about various sporting activities they took part in at the local leisure centre, including football, cricket, golf, badminton, cycling, swimming and horse riding. Other people were employed or attended local day centres. Staff told us they thought people had enough to do to occupy their time. One member of staff said, "[Activities] are very much based on what people want to do. They have the right to say yes or no."

People were supported to keep in touch with family and friends and any contact with relatives or friends was recorded on a contact sheet. Family and friends were made welcome whenever they visited the home. We saw that some relatives visited the home for a birthday tea on the day of the inspection and spent time with all of the people who lived at the home.

The home had a complaints policy and procedure in place and documents to record any complaints received. People had a copy of the service user guide in their bedroom, bungalow or flat and this contained a copy of the complaints procedures. We checked the complaints log and saw that there was a thorough record of complaints received and the action taken to resolve the complaints. Complaints were audited on a regular basis so they could be monitored by the registered provider and registered manager.

People who lived at the home told us they would speak to any of the staff if they had a concern or complaint. One person said, "Staff would listen and they will try to put it right if they can" and another told us, "If I'm not happy I tell the staff." Staff told us that most people who lived at the home could express concerns or make a complaint, but they would make a complaint on their behalf if needed. They were confident any concerns or complaints would be dealt with effectively. One member of staff said, "[Name of registered manager] is extremely approachable." Relatives told us they were confident any concerns or complaints they made would be listened to and dealt with, although one relative added they had never had anything they wished to complain about.

People who lived at the home were given satisfaction surveys to complete. We saw the results of surveys that had been carried out in September and December 2016. Comments from people included, 'I do know how to make a complaint', 'I like living at Apple Tree House' and 'I have confidence in my key worker'.

Weekly meetings were held for people who lived at the home. People told us, "We're asked if everything is ok and if we are happy" and "[Staff] ask us if everything is ok." We saw the minutes of recent meetings and these showed the topics discussed included holidays, social events, menus (everyone said they were happy with the current menus) and staffing (everyone said they were happy and had no complaints about staff or in

general). Staff had signed the record to show they had read these minutes.

One person had expressed an interest in moving into the home and a gradual introduction to the home to meet people who lived there and the staff had been arranged. This person had been visiting the home since August 2016. The aim of this was to help people settle into their new surroundings when they became a permanent resident.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) since 14 September 2016. This meant the registered provider was meeting this condition of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed CQC of most significant events in a timely way by submitting the required 'notifications'. However, they had not understood that they were required to submit notifications about alleged abuse even when the local authority safeguarding threshold tool indicated that the incident should be managed 'in house'. This shortfall has been addressed outside of this inspection process.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely. In addition to this, the current ratings for the service awarded by CQC were clearly displayed in the home, as required.

The service had policies and procedures in place for all areas of care and employment, including those for person-centred care, medication, complaints, managing challenging behaviour, safeguarding adults from abuse, intimate care, staff supervision and whistle blowing. These were reviewed and updated on a regular basis.

We saw that there were clear lines of communication between the registered manager and staff. The registered manager knew about the specific needs of people living at the home. We asked people if they felt able to speak with the registered manager. One person said, "I like [Name of registered manager] – you can always rely on her and I can talk to her" and another told us, "Yes, I can talk to [Name of registered manager] and I also like talking to my key worker."

Staff told us the home was well managed. Comments included, "I can talk to [name of registered manager] if I need to. They are one of the best managers I have ever had. They are understanding and they do the job properly", "I love working here", "[Name of registered manager] is not a bully but they deal with issues" and "[Name of registered manager] is always at the end of a phone. They are never bad tempered and always have time for staff. The best manager I've ever worked for." One member of staff added that the registered provider was also, "Always at the end of the phone and a good person to work for."

Staff told us that they attended meetings and that they could make suggestions or ask questions at these meetings. They were able to add items to the agenda and were always asked if they had 'any other business' to be discussed. The minutes of meetings in June and August 2016 showed that topics discussed included medication, monthly care plan updates, kitchen duties and finances. A meeting for team leaders had been held in October 2016. Topics discussed included staff supervision, care plans and 'resident' meetings. Staff

had signed a document to show they had read the minutes of these meetings.

Staff received satisfaction surveys approximately every three months and the responses we saw were positive. Surveys had also been sent out to health and social care professionals, or other stakeholders, in December 2016. The registered manager was waiting for responses and told us that they would then analyse this information to see if there were any areas that required improvement.

The relatives we spoke with confirmed that they had received satisfaction surveys and that they felt their views were listened to. All relatives who we spoke with told us they would appreciate being invited to a relatives meeting. We fed this back to the registered manager on the day of the inspection. They told us that the feedback they had received indicated relatives were not interested in attending meetings. However, following our discussion they told us they would organise a meeting and invite relatives to attend.

We saw a letter that had been sent to relatives informing them that the response to the most recent relative's survey had been poor. They added, 'If you would prefer a one to one meeting, please do not hesitate to contact [name of registered manager]."

We saw a variety of audits were being carried out to monitor the safety of the service and whether the service was meeting people's assessed needs. This included audits of medication, incidents, staff training, complaints, accidents, daily notes, cleaning and people's finances. A note was made of any action required. For example, the staff training audit carried out in December 2016 identified that staff required refresher training on the topic of epilepsy and this had been booked for February 2017. The registered manager carried out an additional audit in June 2016 that was based on the Safe, Effective, Caring, Responsive and Well-led areas of the CQC key lines of enquiry. The audit recorded details of any areas that required improvement and was submitted to the registered provider for monitoring purposes. However, we noted there was no date to record when these identified actions had been completed.

The registered manager described the culture of the service as "Friendly and homely" and added that staff were approachable and promoted independence. We asked staff to describe the culture of the service. Comments included, "It's a home. They are a family" and "The atmosphere is really good. The service users are welcoming and happy to see you." Comments from people who lived at the home included, "Nice people and food. [Name of registered manager] is very nice – everyone is nice", "It's friendly and happy", "It's friendly and they care about us" and "I'm happy living here." Relatives told us, "This is one of the best care homes in the area. There is a lovely family atmosphere" and "There is a smashing group of staff. I have seen a great improvement. It's a really good home – there couldn't be anywhere better."

Staff told us that they would discuss any incidents that had occurred. Although staff could not think of examples, they were confident that any issues would be discussed openly. One member of staff said, "We would talk openly. We can tell [name of registered manager] anything." Staff also said they would use the home's whistle blowing policy if needed, and that they were confident the registered manager would respect their confidentiality.

The registered manager told us that they kept up to date with good practice guidance by checking the CQC website. They also received updates from the Safeguarding Board and the local authority. In addition to this, they received policy and procedure updates from a private company.

Although there was no reward scheme at the home, the registered manager told us that it was important to praise staff and thank them for their hard work. They said that they did this in staff supervision meetings, but that they also had an 'open door' policy.