MCCH

Woodgate

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 April 2018 and was unannounced.

Woodgate is a care home managed by MCCH Society Ltd. The home offers accommodation and long term care and support to up to six adults with learning disabilities in a purpose built bungalow. There were six people living at the service when we inspected.

Woodgate is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Woodgate provides accommodation and personal care. The accommodation is in a bungalow in a quiet residential area, with bedrooms, bathrooms and all facilities on the ground floor to provide fully accessible services to people with physical disabilities. There is a communal lounge, a dining room and a conservatory/activities room and a garden to the rear of the home. Woodgate was previously inspected in November 2015 where they were rated as Good. This is the first time that the service has been rated as Requires Improvement.

There was a registered manager at the service. 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.

People did not consistently have their dignity upheld. One person was wheeled through the service on a shower chair without being fully covered and the same person was later left on the toilet with the toilet door open. You can see what action we told the provider to take at the back of the full version of the report.

People were kept safe from abuse and harm and staff knew how to report concerns around abuse. There were sufficient numbers of staff deployed to meet people's needs and ensure they were kept safe. Risks had been managed safely and where potential hazards were identified they had control measures applied to reduce the possibility of harm.

People received their medicines when they needed them from staff who had been trained and competency checked. Staff understood the best practice procedures for reducing the risk of infection; and audits were carried out to ensure the environment was clean and safe. The service used incidents, accidents and near misses to learn from mistakes and drive improvements.

People had effective assessments prior to a service being offered and care outcomes were planned for. Staff understood what support each person required and were trained in key areas to carry out their roles. Staff had been supervised effectively by their manager and their performance had been appraised. People were supported to eat and drink enough to maintain good health and staff used nationally recognised guidance to ensure people had a balanced diet.

The service worked in collaboration with other professionals including local health teams to ensure care was effectively delivered. People maintained good health and had access to health and social care professionals. Environments were risk assessed to ensure people were safe and met people's individual needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful and the least restrictive option.

Staff knew people's needs well and people told us they liked their staff. People and their relatives were consulted around their care and support and their views were acted upon. Staff treated people with kindness and spoke warmly about the people they supported.

Some people were not able to go out as often as they would like. Some people went out more frequently than others. We have made a recommendation about this in our report.

People's needs were fully assessed and care plans ensured that personal details were carried through to care delivery. There was a complaints policy and form, including an accessible format available to people. Complaints were used to improve the service delivered to people. People at the end of their lives were able to receive a pain free and dignified death.

There was an open and inclusive culture that was implemented by effective leadership from the management team. People and staff spoke of a person centred culture that was empowering. The management team understood their regulatory responsibilities.

People, their families and staff members were involved in the running of the service. There was a culture of learning from best practice and of working collaboratively with other professionals and health providers to ensure partnership working resulted in good outcomes for people.

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

Woodgate was safe.

People felt safe and were protected from the risk of potential harm and abuse.

Risks to people, staff and others had been assessed and recorded and control measures were effective in reducing potential harm.

There was a sufficient number of staff to ensure that people's needs were safely met.

People who received support with their medicines had them when they needed them.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Lessons were learned when things went wrong and accidents and incidents were investigated with learning fed back to staff.

Is the service effective?

Good

Woodgate was effective.

People received extensive assessments that ensured effective support outcomes were set and worked towards.

Staff received effective training to meet people's needs and carry out their roles.

People were supported to eat and drink enough to maintain good health.

Staff members worked effectively to ensure the care people received was effective when they moved from the service.

People were supported to remain as healthy as possible and had access to healthcare professionals.

The building was purpose built and met people's needs.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice.

Is the service caring?

Requires Improvement

Woodgate was not consistently caring.

People were not always supported in a way which promoted their dignity and privacy.

People were supported by staff who knew them well and treated them with kindness and compassion.

Staff used a variety of communication tools to support people to express their views.

Is the service responsive?

Good

Woodgate was responsive.

People's needs were assessed, recorded and reviewed and they were included in decisions about their care and support. However, some people were not able to go out as much as they wanted to or as much as others.

A complaints policy and procedure was in place and available to people.

People at end of life care received a pain free and dignified death.

Is the service well-led?

Good

Woodgate was well-led.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people.

Staff, people and their relatives had been involved in the running of the service.

The service continuously learned and improved, and implemented positive changes.

The service worked effectively in partnership with other agencies.

Woodgate

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 16 April 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted local safeguarding and social work teams and looked at notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury.

During the inspection we spent time with people who live at the service. We spoke with two people, the registered manager, senior carer, and one carer. After the inspection we received feedback from two relatives. We looked at three people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

Good

Is the service safe?

Our findings

People were protected from abuse by staff who had been trained in safeguarding adults and understood their role in keeping people safe. The registered provider had a safeguarding adults policy and procedure with responsibilities allocated to staff within the organisation and a flowchart setting out what to do in situations where abuse was suspected or has been reported. The policy reflected the newer definitions of abuse, such as modern slavery and gave guidance for staff on what to do if they suspect a manager was involved in abuse; what to do once a safeguarding had been raised, and how to report under the Duty of Candour. The Duty of Candour is a legal duty to be open and honest with people and their families when something goes wrong. The registered manager kept a copy of the local authority safeguarding adults multi-agency procedure as well as the London Multi-Agency Safeguarding Policy and Procedures. In the past 12 months there had been three safeguarding referrals made to the local authority. We reviewed these and found that each had been referred appropriately and that action had been taken by the provider to keep people safe. There had been one incident where the registered manager felt that staff did not understand the full scope of safeguarding issues, so the registered manager had booked additional training with a focus on the issue concerned.

Individual risk assessments for people were reviewed monthly. They contained the hazard, type of harm possible, a risk rating before control measures were applied, what safety measures staff were to follow, and a new risk rating with the safety measures applied. There was also a section for further action related to potential risk. The risk assessments had been completed effectively for every identified risk area. People had positive behaviour support plans (PBSP's) in place to help staff understand, prevent and manage any behaviours that others may find challenging. The PBSP's set out how the person would present when things were going well and what potential triggers there may be for anxiety to rise, such as new people visiting the service. Possible behaviours had been described and strategies to support the person were in place; for example, using positive language, reassurance and key phrases. There were further strategies if the person continued to be agitated such as limiting verbal communication and giving the person space. Once the incident was over there was a plan for how to support the person in the recovery phase. People had been supported to take positive risks, such as one person who was known to become challenging at mealtimes who had been supported to have their meals with their peers with a change to their support to enable this. Staff had received training in food hygiene and the service was using the Safer Food Better Business pack. The Safer Food Better Business pack is a tool that helps businesses to comply with food hygiene regulations.

Risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. The fire risk assessment was effective and up to date. Fire drills were happening and records showed that this included night time drills when staffing levels were lower. Staff were aware that each person had a personal emergency evacuation plan (PEEP) for the risk level associated with evacuating people safely in the event of a fire. A PEEP gives details of the support each person would need to leave the service in the event of an emergency such as a fire. Safe recruitment processes had been followed and recruitment systems were robust. We checked the recruitment files for three members of staff. In each case thorough recruitment procedures were followed to check that staff

were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The employment history of each newly recruited person had been tracked to maintain the safety of the recruitment process. References had been taken up before staff members were appointed and were obtained from the most recent employer where possible.

There were sufficient staff deployed to keep people safe and meet their needs. One relative told us, "There are always three or four people there doing different things so there's enough staff." Another relative said, "There seems to be plenty of staff when I have been there and never seen anyone without help or waiting for staff." We checked one month of staff rotas and saw that the levels of staffing were at the assessed needs and were enough to keep people safe. People told us that there were enough staff. One person told us, "I can find staff if I need them." The service provided a mixture of shared and one to one hours depending on people's needs. Support hours were agreed and funded directly by the local authority and the service was providing the agreed levels of support. One person was receiving one to one support to keep them and others safe. There were four staff working in the morning and four staff working in the afternoon with two staff working at night time, including the one to one support. The service employed some agency staff but where this was the case the staff were inducted and working alongside experienced staff.

People received their medicines safely, when they needed them, and from trained staff. The service used a monitored dosage system where tablets arrived from the pharmacy pre-packed and in separate compartments for each dosage time of the day. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted daily and counter checked. MAR charts had been signed to indicate that people had been given their medicines. Medicines were stored in a lockable cabinet with different areas of the cabinet for different people's medicines to reduce the risk of errors. Controlled drugs (CD's) were kept in a locked cabinet inside another locked cupboard and the CD book had been audited accurately. Controlled drugs are prescription medicines that are controlled under the Misuse of Drugs legislation (and subsequent amendments).

Staff ensured that people were able to receive their medicines safely even when people were reluctant to take them or refused them. There were guidelines for one person who refused medicines that had been reviewed and signed by their GP. The GP had confirmed which medicines could be safely refused and which medicines would need to be administered. For those medicines the person could not do witrhout there were clear timelines such as epilepsy medicines being administered within six hours of the prescribed time. The GP had confirmed that tablets could be taken covertly, for example on a spoon hidden under jam, and a best interests meeting had taken place in line with best practice.

People were protected against the risk of infection and there were control measures in place to keep people safe. There was an up to date risk assessment for infection control which covered areas including cross contamination, food preparation, controlled waste and laundry. There were effective control measures applied to each area of identified risk; for example, all continence products were to be placed in yellow bags then immediately to controlled waste bins that were emptied only by a specialist contractor. The service had a laundry room where clean and soiled laundry was kept separate with a red bag system in place to contain any soiled laundry and reduce the risk of cross contamination. There was a cleaning rota where a different area of the service was identified for intensive cleaning for every day of the week. For example on Mondays the kitchen would be the focus so staff would clean tiles and all cupboards and sanitise door handles. Staff were reminded of the importance of infection control and it had been discussed at every team meeting and supervision.

When things in the service went wrong the registered manager ensured that lessons were learned and shared with the staff team. We reviewed one incident where a person had suspected but unexplained burns. These burns had been appropriately treated and the registered manager had ensured that all staff were trained in kitchen safety and implemented a kitchen safety file. The registered manager also worked with the speech and language therapist to develop guidelines for cooling hot drinks. We observed that the information relating to this was kept in the kitchen displayed on the wall. The learning from this was shared with staff during a team meeting and in staff handovers, and the registered manager was doing spot checks. Staff were preparing hot drinks and ensuring that they were served at a safe temperature for people. Accidents and incidents were being monitored by the registered manager and the provider. One incident related to behaviours that may challenge. This had resulted in staff receiving training to ensure they and people were safe'.

Good

Is the service effective?

Our findings

People's needs were assessed and their care was planned to ensure their needs were met. There were assessments of people's needs prior to a service being provided. Pre-admission assessments examined people's needs in terms of their religious and cultural needs, any relationships, marriages or children people had or other important relationships. People's disabilities were assessed in terms of the support that people needed as well as specific questions about, for example autism. There was appropriate use of nationally recognised assessment and management tools for malnutrition and wound care. The care plans were written in a structured way that tracked needs and delivered good outcomes for people and staff were working in line with best practice.

Staff had the skills, knowledge and experience to deliver effective care and support. Staff had received training in a range of courses relevant to their roles. The provider had identified core training courses such as, first aid, fire safety, food hygiene and dementia. The registered manager had requested additional training updates for staff whose training had expired or for new staff. Training was delivered through a mix of face to face courses and e-learning courses completed on a computer. For medicines training staff had to complete an e-learning course and then attend classroom based training. After this they completed a booklet to demonstrate their competency, before shadowing staff and being assessed by the registered manager. We reviewed the training plan and saw that where there were gaps these had been planned for and refresher courses booked, and that staff had completed the training they needed. One staff member told us, "I think the training is good. I can go to the head office to catch up on computer based training and we have safeguarding training this week."
New staff employed were inducted using the Care Certificate to ensure their induction was effective and they had a good grounding in care and support. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care services are expected to uphold. Staff had received supervision and appraisal from their line manager. Supervision in care settings is a process whereby through regular, structured meetings with a supervisor, care staff can develop their understanding and improve their practice.

People who required assistance to eat and drink due to their disability were provided with specialist equipment and given support by staff. Some people used adapted plates and cutlery to enable them to eat more independently. One person was experiencing several issues at mealtimes and this need had been reflected in their care plan. The registered manager had implemented strategies to enable the person to eat their meals with other people despite the person experiencing a number of challenges. For example, staff were instructed to place meals in front of the person even if they were verbally refused, as the person may want the food, and there were specific timeframes for staff to bring the person to the dining room. These procedures had enabled the person to maintain their appetite and a healthy weight. People with risks to their eating and drinking related to issues with their swallowing had been seen by a speech and language therapist and recommendations were in place, such as food to be cut up in to small pieces and to only drink from a certain cup. These guidelines had been signed as understood by the staff team. Staff were using fluid charts to ensure people were sufficiently hydrated. Food intake was being recorded on a menu record. Staff recorded things such as, '[person] had jam on toast for breakfast, chicken pasta for lunch and jam sandwich

for snack.' There was a healthy recipe and meal idea folder with a selection of healthy recipes with photos to encourage people to eat healthy meals. The service was using Public Health England's 'eatwell plate'. This is a guide to show how much of each food group should be eaten overall for good health.

Staff worked together to ensure that people received consistent and person-centred support when they moved from or were referred to the service. The service was offered as a home for life for people who want this and whose needs could be met at the service. However, one person was due to move to a different service that would better suit their changing needs. The registered manager showed us a file containing key documents and guidance for the new service. The registered manager told us, "We had a transition planning meeting with the potential provider." We discussed the plan and the registered manager told us that they had ensured that the transition was done in a person centred way that would not be rushed. Staff were aware of the person's proposed move and were working to ensure the transition was smooth.

People's health needs were understood by staff and had been planned for in care plans, including for mental ill health. One person had a diagnosis that affected their short term memory and staff were directed to introduce themselves on every shift and before every task if the person was experiencing confusion. There was a detailed description of how to help the person with personal care, as this had been an area their mental health issues had previously impacted upon. The care plan directed staff to break tasks down, such as each stage of having a bath, into easy to understand sections of support.

People had access to healthcare professionals and were supported to maintain good health. We reviewed one person's medical records and saw they had been supported to 11 GP appointments in the past year for a range of issues from blood tests to medicines reviews. People had been supported to access psychiatric help where appropriate. People with complex needs were being cared for as part of a multi-disciplinary team. One person had meetings around their condition with the registered manager, a behaviour specialist, care manager, psychiatrist, advocate, learning disability nurse, and GP to discuss changes in their presentation. As a result they had attended a memory clinic. All people had hospital passports. A hospital passport is a document for people with learning disabilities to provide hospital staff with important information about them and their health needs when they are admitted to hospital.

The building was purpose built as a four bed home that had since been converted to a six bedroom service. One relative told us, "It works very well and is all on one floor and easy for people to move around with two big communal areas." The building is all on one floor with wider doorways and wide corridors to make it easier to move around in a wheelchair. The bathroom was adapted with a chair bath that lowered people with mobility issues in to the bath. There was also a wet room to enable people with any level of mobility to receive personal care. There was level access to the garden through a utility room and people were encouraged to use their garden. The garden was accessible with a large patio area and seating area that spanned the length of the building. There was also a lounge and conservatory area with seating and had been used for people to play games.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 any conditions on authorisations to deprive a person of their liberty were being met. People's right to make decisions was promoted and the principles of the MCA were adhered to. Where people had a DNAR in place there had been an MCA assessment and best interest meeting where people lacked capacity. DNAR stands for Do Not Attempt Resuscitation: a DNAR form is a document issued and signed by a doctor, which instructs medical teams not to attempt cardiopulmonary resuscitation (resuscitation after a heart attack). There were also MCA assessments made for less complex decisions, such as understanding finances. Each assessment had been made in line with the Mental Capacity Act 2005 Code of Practice. Applications to deprive people of their liberty had been made appropriately and where they had been granted they were being tracked by the registered manager.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not consistently upheld. One person was observed to be transported to the bathroom in a shower chair. However, staff had not fully covered the person as they wheeled them through the service and parts of their body were exposed. The same person was then seen to have been left sat on a toilet with the toilet door open and they were exposed to people walking past. We asked a member of staff whether toilet doors were usually left open and were told, "Sorry, I didn't realise I had." People's information was kept private. Care plans were locked away in a cabinet and the keys to this cabinet were kept in a safe to ensure that access to confidential information was restricted.

The failure to treat people with respect or dignity is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed other examples that showed that people had been supported in a way that upheld their dignity and staff were sensitive to people's need for privacy. For example, doors were closed during personal care and people's continence needs were addressed discreetly. Staff were able to describe to us how people required their care and how this would be delivered in a way that upheld their human rights. One staff member told us, "[Person] may take themselves off to the toilet and leave the door open but we would close it and explain what we're doing."

People were treated with kindness and compassion by their staff and were given emotional support when needed. We discussed one person's needs with a staff member. The person did not like anyone touching their face or hair which made washing their hair or having it cut was very difficult as the person would become distressed. The staff member told us, "We started doing massages to de-sensitise them. They allowed me to massage their hand and arms and then I could progress and do a minute or two on their face." This support had made it easier for the person to receive care around their face and hair.

People and their relatives told us the staff were caring. One person told us, "The staff here are very kind; they treat us well." One relative commented, "The staff know a lot about the way [person] is. If I pop in they can say why he looks, for example, fed up, and it's all done by observations." A second relative said, "The staff are caring because they go the extra mile. They worry about the residents and involve the family in everything which shows they care about [relatives] best interests." When staff returned to the service from outings, or came in on shift, they greeted people affectionately and asked questions about their days. Staff offered people different activities within the home and helped them to set up different board games or puzzles. Staff complemented people on their appearance, saying things like, "I love your trousers they look really smart, and your shiny bracelet is lovely."

People were involved in making decisions affecting their care and support. There were regular 'Tenant meetings' that were structured to ask questions and engage people in their service. These questions were in accessible format to help involve people and asked things such as, 'Are you happy with the choice of meals?' There was a section asking people what they would like for dinner and this was completed every week to compile a menu. Staff used picture cards of different meals to help people choose their option. People were

asked at these weekly meetings whether they were happy with the house, the support they received and with outings. The registered manager told us, "We involve people in everything we do on a day to day basis. We ask people what they want to eat, where they want to sit and promote choice on a daily basis." One person's files showed that they were involved in monthly reviews and these had identified a range of issues such as not sleeping well and their mental health fluctuating. Details such as medicines changes were discussed and any changes were updated in care plans. One person had a 'mood diary' they were involved in completing to track their mental health.

People's independence was encouraged through care planning. One person had a plan setting out what they could do for themselves so that they could maintain their daily living skills. Examples, such as being able to put away their laundry, manage their own continence and understanding which staff were working were explained in good detail with pointers for staff, for example checking the temperature of bathwater, or how to maintain people's safety.

Good

Is the service responsive?

Our findings

Some people were not able to access the community as often as they would like. People had community engagement logs to record when they went out for activities. We checked the file for one person and it had recorded frequent activities, such as shopping trips and using a sensory room. However, we reviewed the records for another person that had only seven outings recorded in the past two months. This person had a support plan, 'How to support me out in the community' that stated the person enjoyed going out with support. One person had a description of what a good and bad day looked like for them. A good day was described as when the person can go out for a ride in the car and for a coffee, and a bad day was described as when the person was not able to go out. This person had frequently had days when they were not taken out. Another person had a weekly activities planner in their room but this did not match the planner in their file or the recorded activities in their community engagement logs. We discussed activities with the registered manager and was told that there were issues related to people's wheelchairs and finding drivers to take people out. The registered manager explained that one person required two to one support when they were highly anxious, but were not funded for this level of support, and this could impact their ability to take other people out. The registered manager confirmed with us that no one was funded for day services.

We recommend that the registered manager reviews activity provision for people to ensure activities match people's preferences and people can access the community equally.

Some people had access to a range of activities in the community. Some attended a gardening activity run by the provider. Other activities that people attended included sessions at a sensory room, craft activities, playing games in the service, going for walks, going out for meals or tea and cake, shopping trips, making cakes, and film evenings at the service. One relative told us, "They take [name] out to the pub and they go shopping and in the summer they go for trips out." One staff member commented, "When people go out they like to go for meals out. We went to a valentine's party and a Christmas panto, and switching on the Christmas lights. People do things that you would do yourself."

Care plans contained personalised information, such as one page profiles which gave individualised descriptions of people's needs. We reviewed one profile that described the person's particular hobbies and interests and how collecting some items that may seem like litter or rubbish to other people are 'treasure' to the person. There was a description of how staff could support the person to hide and find certain objects within the garden to engage their interest. One relative told us, "I worried about [person] before but not where they are now and they always ring if something is wrong. Every issue they had they have rung us about. I think [person] feels at home where they are now."

The service had identified people's communication needs and shared them with staff in care plans. One person needed time to process information and to not be rushed when asked a question, and this was explained. The same person used different names for some everyday objects and this was clearly explained so that staff would be able to communicate effectively with them. Another section of the care plan explained to staff how the person's communication needs changed when they were feeling in a low mood and directed staff to alter their approach to the person to offer personalised care in these moments. People had

separate communication plans that examined key aspects of people's communication needs such as, how staff know the person wants to interact; things I do; things I do that may not make sense to others; things I like and things I might say when feeling anxious. Under each of these headings there was personalised information about how each individual communicated.

The registered provider was meeting the Accessible Information Standard. The Accessible Information Standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. All support plans were available in an easy read format. We reviewed one person's support agreement that had been written in accessible format to help them understand; it had been written with bold, large text, using short sentences with pictures to supplement the words.

There were systems in place for people to be able to complain and for staff to respond appropriately. Each person had written guidance on how to make a complaint and had a mental capacity assessment completed to ensure they understood how to complain. The registered provider had a complaints policy that was up to date and contained relevant information. The complaints policy contained a commitment to respond to written complaints within a 28 day timeframe, a complaints form, and a flowchart for how to resolve complaints. If the resolution of the complaint was not satisfactory people were signposted to the local government ombudsman. Staff were reminded in complaints guidance to be vigilant for changes in behaviour that may indicate that people were unhappy about something. There was an easy read version of the complaints procedure and this was also displayed in the kitchen where people would regularly see it. There had been no complaints received by the service in the past two years.

Nobody living at the service was currently receiving end of life care. People had end of life care plans although some people had expressed a wish not to discuss dying. Where people's families had paid in advance for funeral plans there were clear instructions for what type of ceremony people waned, taking in to account places of worship and family traditions and beliefs. This also included hymns to be sung where these had been identified. The last person to be supported in the service with end of life care was in 2016. The deputy manager had started to talk to families about planning ahead for end of life decisions and some families had reported their wish to do this.

Good

Is the service well-led?

Our findings

The registered manager kept the day-to-day culture in the service, including the values and behaviour of staff, under review. There was a strong management presence in the service with a registered manager, deputy manager and senior carer, meaning that there was nearly always a senior staff member available. The registered manager had worked on the culture within the service around whistle blowing following an incident involving night staff. There had been an action plan produced which evidenced more frequent supervisions, tailored training around whistle blowing to address the issue, waking night spot checks and giving informal action plans to staff. There was visible leadership within the service that inspired staff to provide a quality service. During our inspection one person was becoming distressed and the registered manager broke off our conversation to check staff were OK and to offer support.

The service had a clear set of values around person centred care that the registered manager was in the process of embedding in to practice. There were corporate values that the provider had in place and we asked the registered manager what these meant to the service and were told, "It's about being person centred and for the residents it's about staying on top of their physical health needs first. We're making people's lives exciting and ensuring they get the most out of life." The registered manager and staff shared a good understanding of the key challenges the service faced. There was a high level of specialist input in to people's physical health needs as people aged. The service was also working to assist people to communicate as this had not been a part of their early lives. The registered manager was aware of issues facing the service in terms of recruiting staff and was working with the provider to ensure there were enough staff to meet people's needs.

The governance framework ensured that quality performance, risks and regulatory requirements were understood and managed. The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aims to ensure that providers are open, honest and transparent with people and others in relation to care and support. The registered manager confirmed that all incidents that had met the threshold for Duty of Candour had been reported to people's relatives. The service had robust arrangements to ensure the security, sharing and integrity of confidential data, in line with data security standards. There had been a recent audit completed to ensure that the provider was compliant in the new data protection regulations and the registered manager had been given a list of actions to complete to remain compliant.

The registered manager was supported by the provider in their role. The registered manager told us, "The senior operations manager is brilliant and I feel so supported. If I come across something new and need advice they are really good and there are any number of people [from the organisation] I can ask." The registered manager participated in a series of meetings with senior managers and other registered managers and was able to contact one of the provider's directors if needed. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about a service can be informed of our judgements. The

provider had displayed the rating conspicuously in the service. The service had robust arrangements to ensure the security, sharing and integrity of confidential data, in line with data security standards.

People, their families and staff members were involved in the service and regular feedback was sought through meetings and questionnaires. The service had strong links with the local community. Some people attended a local 'Salvation Army over '60's club', other people attended a local gardening activity at a horticultural centre. People were well known in the local area and frequently used shops and facilities in the community. The service held regular parties for events and celebrations and invited the local community and other services to join. One relative commented, "At times like Christmas they arrange parties and go to other homes; as a large organisation that's a great benefit as these things are arranged." Staff were involved in the service and had been encouraged to suggest new ways of working. Staff members had forwarded ideas for improvements in staff meetings. One instance involved handover sheets and the allocation of tasks for the days shift. Some staff felt that this system was not working and proposed a new system that separated each staff member out and allocated specific tasks. Another member of staff put together a list of active support tasks to encourage community support. The service enabled and encouraged open communication with all people who use the service and their family, friends, and other peers. All people with families had dedicated time that had been allocated to support them to call their families. One person called their family and for other people staff called families at agreed intervals. Families, friends and peers were free to visit at any time and were welcomed to the service. One relative told us, "I never announce visits we always just turn up and it's never an issue." A second relative commented, "It's a very welcoming place and there's always someone to speak to."

The service was continuously learning and improving and learning was shared with staff members. Resources and support was available to develop staff teams. The registered manager told us, "Our training team is fantastic; we offer a huge range of internal training for staff development." Where the registered manager had identified a training need for staff this had been outsourced in order to provide it, such as with specialist training to support someone fed via a tube. Information from incidents, investigations and compliments was used to inform learning and drive quality. Incidents were investigated by the registered manager and outcomes had been recorded and shared with the staff team. There had been one incident where a person became unwell and was threatening staff. The incident was investigated and a specialist behaviour team were called in to help make the environment safer and to train the staff team (which was completed within two days). Information technology systems had been used to effectively monitor and improve the quality of care. The provider had an electronic system to upload and monitor all quality information which was accessible to senior managers to give extra oversight.

Audits had been used to identify shortfalls in service and drive improvements. There had been a new system of audit introduced where the registered provider would conduct a service wide audit every six months. We saw the latest audit and actions had been generated. These had been promptly actioned by the registered manager. There were other periodic audits such as monthly finance and medicines checks as well as unannounced checks at night time conducted by the registered manager. There were monthly checks of areas including support plans and referrals and these had identified improvements which had been acted upon.

The registered manager had a good working relationship with the local services and was working effectively in partnership with key organisations. The registered manager described a very close working relationship with local safeguarding and social work teams. The registered manager told us, "When one person became unwell I ensured that there was a multi-disciplinary meeting where speech and language, physiotherapy, occupational therapy, and all the other services involved were working together." People had regular health appointments and the service worked closely with health teams. Health and social care services were

managed through one community learning disability team and the registered manager had forged good relationships with these services. The service shared appropriate information and assessments with other relevant agencies. Where confidential information had been shared with the local authority this had been done via an encrypted email. The registered manager told us, "Information is shared on a need to know basis. We encourage professionals to view the information at the service rather than sending it out."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure that staff consistently supported people in a way that upheld their dignity.