Voyage 1 Limited

Westbury House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Westbury House is a residential care home for up to 13 adults with a learning disability. There were nine people living at the service at the time of inspection. People had lived at the service for a long time and the amount of personal care and support they needed had increased. The accommodation was in one building, arranged over two floors. There was a passenger lift for people who could not use the stairs. There was a communal lounge, a smaller lounge, dining room and a garden.

Westbury House 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 inspection took place on 19 March 2018 and was unannounced.

At the last inspection, on the 30 December 2015 the service had an overall rating of 'Good.' At this inspection we found the evidence continued to support the rating of good. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The 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 using the service can live as ordinary a life as any citizen.

A registered manager continued to be employed 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.

At this inspection we found the service remained 'Good'

There continued to be systems in place to keep people safe and to protect people from potential abuse. The registered manager continued to assess and minimise risks. Peoples care and support plans remained up to date and accurately reflected people's needs. Medicines were managed safely and people received their medicines on time and when they needed them. Staff had undertaken training in safeguarding and understood how to identify and report concerns.

There was sufficient numbers of staff to meet people's needs. New staff had been recruited safely and pre-employment checks were carried out. Staff training had been consistently updated and staff had the skills and knowledge they needed to support people with learning disabilities.
Staff had regular supervision meetings and annual appraisals.

People's needs had been assessed and their support was delivered in line with best practice in learning

disability services. Peoples support was individualised to them and met their needs. Staff were aware of peoples life story and respected their choices. Activities were planned around people's known likes and dislikes and people had a choice in the activities they undertook.

People continued to be supported to maintain their health and wellbeing by eating and drink enough and by accessing a balanced diet. People were supported to maintain their health and had access to healthcare services. When people accessed other services such as going in to hospital they were supported by the service staff and there was continuity of care.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; there were policies and systems in the service support this practice.

People were treated with kindness, respect and compassion. Staff took the time to listen to people and engage with them in a meaningful way. Staff knew people well and understood how people communicated. People were supported to communicate with other people and people in the community. People were well known in the community and were supported to maintain relationships with those who were important to them.

People were supported to express their views and had regular access to an advocate. People were supported to remain as independent as possible and make choices and decisions. People's privacy was respected and they were supported to lead dignified lives.

Support was personalised and person centred. Support plans fully reflected people's needs, interests and goals. Staff recognised when people were upset or distressed and responded to this. There was a complaints system in place if people of their relatives wished to complain.

People were supported at the end of their lives. There wishes and preferences were recorded and acted upon.

The environment had been adapted to meet people's individual needs. People who used wheel chairs could move around the service freely and access all areas including the garden. The service was clean and well maintained. Staff were aware of infection control and the appropriate actions had been taken to protect people.

Staff, relatives and community health and social care professionals told us the service was well-led. The registered manager had a clear vision and values for the service. Staff understood the services values and acted in accordance with them. Staff and the registered manager understood their roles and responsibilities. The provider and registered manager regularly audited the service to identify where improvements were needed. There were systems in place to seek feedback from people, relatives and other stakeholders in order to improve the service. Relatives told us that they felt well informed and that communication was positive and proactive.

When things went wrong lessons were learnt and improvements were made. Staff understood their responsibilities to raise concerns and incidents were recorded, investigated and acted upon. Lessons learnt were shared and trends were analysed.

The service worked in partnership with other agencies to develop and share best practice.

Further information is in the detailed findings below.

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 remains Good

Is the service effective?

Good

The service remains Good

Is the service caring?

Good

The service was caring.

People were treated as individuals and able to make choices about their care.

People were involved in planning their care through a person centred approach and their views were taken into account.

People experienced care from staff who respected their privacy and dignity.

Is the service responsive?

Good

The service remains Good

Is the service well-led?

Good

The service remains Good

Westbury House

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 was a comprehensive inspection. The inspection took place on 19 March 2018 and was unannounced.
The inspection team consisted of two inspectors.
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 looked at the previous inspection report and notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

People did not engage verbally about their experiences of the service. People used a range of communication styles including behaviours and body language. We gathered information about the care people received by observing how people responded to staff when care was delivered. During the inspection we were able to observe the interaction between people and staff in the communal areas. We observed the medications round at lunch time. We looked at three people's support plans and the recruitment records of three staff employed at the service. We viewed a range of policies, medicines management, complaints and compliments, meetings minutes, health and safety assessments, accidents and incidents logs and quality audits. We looked at what actions the provider had taken to improve the quality of the service.

We spoke with three relatives of people, to gain their views and experience of the service provided. We also spoke to the registered manager and four staff.

We contacted two health and social care professionals for feedback about the service. We also spoke to another health and social care professional who was visiting the service on the day of the inspection.

At the inspection we asked the provider to send us the staff training matrix, information on water system testing and any compliments they have received about the service. This information was received by us in a

timely manner.

Good

Is the service safe?

Our findings

We observed that people were happy, laughing and relaxed with staff. Staff told us that people would indicate to them if they felt unhappy or unsafe. Staff were able to demonstrate that they knew people well enough to notice to any changes in their behaviour, which may indicate they were unhappy, upset or unwell. Relatives told us, "I have no doubt in my mind what so ever that my relative is safe", "There is always someone there and they [staff] always seemed to know what my relative needs". One community health and social care professional told us, "It is a home I know I can trust to look after my client".

There continued to be a safeguarding policy in place. Staff had undertaken safeguarding training. Staff were able to demonstrate that they knew the signs of possible abuse and gave examples such as unexplained bruising or a change in people's behaviour. Staff knew how to report abuse and told us that they were confident that they would be listened to, but that if their concerns were not taken seriously, they said they would raise concerns with the local authority or Care Quality Commission. The registered manager understood how to report concerns they had to the local authority and protect people from harm. For example, there had been one safeguarding referral made in the last 12 months, which had been reported and investigated. Staff were aware of whistleblowing policy and knew how to contact outside agencies if they felt unable to raise concerns within the service. Staff said about safeguarding, "We have had a lot of training and information. We have just had talk about safeguarding from local authority safeguarding lead." This meant that people were protected by staff who understood their responsibility to prevent harm and report concerns that may need investigation.

Risks to people's individual health and wellbeing continued to be assessed. Each person's support plan contained individual risk assessments including assessments of people's care needs, mobility, diet and hydration and communication. Where risks were identified, people's support plans described the actions care staff should take to minimise the risks. For example, staff signed support plans and risks assessments to acknowledge they understood them. When we spoke to staff they confirmed they understood potential risks and how these were minimised. Risks were discussed, communicated within the team and recorded at shift handover meetings and in team meetings. Records detailed the information shared between staff about risks within the service. The registered manager told us that they tried to identify the least restrictive option to minimise risks. For example, one person was identified as being at risk of falling when getting out of bed. The service purchased a different bed and assessed and adjusted the height of the bed so that the person could get in and out of bed independently and safely. We observed staff following the necessary guidance such as ensuring people had the right aids and equipment when they needed them. For example, there were celling tracking hoists in people's rooms where these were needed. This meant that the risks people may be exposed to were minimised.

The registered manager consistently carried out regular health and safety checks of the environment to make sure it was safe. Where assessments had identified actions were needed these had been undertaken. Equipment was regularly checked, including the lift to make sure that it was safe to use. The provider had arranged for regular servicing of the gas and electricity systems to ensure they worked safely and correctly. Water temperatures were checked throughout the service to make sure people were not at risk of getting

scalded. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. People had a personal emergency evacuation plan (PEEP) and staff and people were regularly involved in fire drills. A PEEP sets out the specific requirements that each person has to ensure that they can be safely evacuated from the service in the event of an emergency.

The provider's recruitment policy and processes were followed to minimise risks. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants had references, full work histories and had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Staff were deployed in appropriate numbers within the service to keep people safe based on a full assessment of people's care needs. For example, people benefited from 1-1 or 2-1 staffing input and additional staff were made available so that people could remain safe when accessing their local community. Staff were available to focus on safety. For example, during the inspection we observed a member of staff was available at all times in the lounge to observe and monitor people's safety. Day time staffing numbers were flexible and the staff rota showed that more staff were made available at busy times. Staff had a good understanding of keeping people safe. Staff told us that if needed two staff were available to support one person if they displayed negative behaviours or moods. The staff rota was planned in advance, this showed that the staffing numbers deployed were consistent with what we had been told and observed. Staff absences, like annual leave were managed in advance to minimise any impact this may have on staffing levels. Back up staff had been recruited to cover staff absences, for example staff holiday. This gave people consistency of care. In addition to the care staff, there was a cleaner, cook and maintenance person employed in the service. This meant care staff could concentrate on meeting people's care needs.

There were policies and procedures in place to make sure that medicines continued to be managed safely and people received them on time. Staff received training on how to give people their medicines and staff competencies were checked on an ongoing basis and recorded. The management of medicines kept people safe. For example, medicines we checked were in date. Bottles and creams were labelled with the date they were opened. Where medicines were applied to people's skin there were body maps to ensure that staff knew exactly where the medicines should be applied. Medicines were stored at the right temperature in a locked cupboard and a medicines trolley. We observed that staff unlocked the medicines cupboard and trolley to remove each person's medicines and locked them again whilst they were administering them. Medicines administration records were complete and accurate. For example, staff signed to show they had administered the persons medicines at the correct time. Medicines were disposed of safely. Some people were prescribed 'as and when necessary' (PRN) medicines. Staff had the guidance necessary to understand when it was appropriate to administer these medicines. There was guidance for staff on what actions to take if a person declined their medication.

People had STOMP plans in place. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines and is promoted by NHS England. Where people had an 'as and when' medicine (PNR) for when they became distressed. There was information to help staff identify when the person was distressed and action plan to enable staff to support the person without the use of medication. A relative told us, "Medication has always been the last resort. They never give them medication just to keep them quiet".

The service was clean and free from odours. The risks of infection and cross contamination were minimised by health and safety control measures based on an up to date infection control policy. These controls included the testing of water systems for legionella bacteria, water outlet flushing and temperature

monitoring, infection control training for staff, safe systems of cleaning, and the provision of personal protective equipment. For example, daily, weekly and monthly cleaning schedules were followed by staff. Cleaning included kitchen extraction hoods and deep cleaning of flooring and furnishings. Staff were provided with infection control training and we observed staff accessing gloves and aprons. The provider audited the effectiveness of cleaning and infection control in the service. There had been three audits so far in 2018. The service had been awarded a five star food hygiene rating by the local authority environmental health officer. Maintaining hygiene, water quality and following good infection control practices reduced the risks of cross infection or exposure to waterborne illness.

Incidents and accidents were recorded and checked by the registered manager for any learning. Steps were taken to reduce incidents and accidents from happening again. Information about safety was analysed for trends to reduce risk and was communicated to the staff. We saw that people's health and safety had been discussed at team meetings to inform and reinforce staff knowledge of the steps that were to be taken to minimise the risk after incidents. For example, staff had changed the way they work with one person to protect their skin and reduce the risk of them injuring themselves because of a harmful repetitive behaviour. Another person had been re-assessed for a new wheelchair after their current wheelchair had toppled over. Learning from accidents and incidents minimised the risks of avoidable harm.

Good

Is the service effective?

Our findings

We saw that people were happy with the staff that provided their care and support. Relatives told us that they were confident that the staff were trained to meet their needs. One relative said, "They loved the staff, especially their key worker". Another relative told us, "I can't praise the staff enough, they are very dedicated the staff and they will look after my relative." Staff told us that the training had improved their knowledge and they felt confident in their role. One member of staff said, "The other staff made me feel really welcome when I started, like I was part of the team".

No one had moved in to the service since the last inspection. Each person's needs had been assessed before they moved into the service and the registered manager and staff had regularly reviewed people's support plans to ensure they continued to represent people's needs. Support plans were updated regularly or when people's needs changed. For example, one person's support plan had been updated after they had a fall to reduce the risk of the incident reoccurring. Staff were able to tell us about the changes to the persons support. Staff and the registered manager were able to demonstrate that they were aware of best practice relating to supporting people with learning disabilities, including reducing some medication used to control behaviours.

Records showed that staff had continued receiving training relevant to their role to support the people they looked after. These included manual handling, communication, autism awareness, basic life support, equality and diversity, safeguarding people, fluid & nutrition, and working in a person centred way. Staff had a period of shadowing more experienced staff until they felt confident to carry out tasks on their own. New staff completed the care certificate, this is an identified set of standards that social care workers work through based on their competency. The registered manager had maintained regular staff supervision and annual appraisal meetings to check staff performance and development. Staff told us, "The training has increased my confidence and my knowledge". A relative told us, "The staff know what they are doing. Whenever I have been there my relative has always been supported correctly and safely."

The food menu was in easy read format with pictures for those who needed help to understand written words. Staff used these pictures when asking people what they wanted for lunch. The registered manager told us that they used pictures to support people to select what food they wanted on the menu. They also told us that they would re-create peoples favourite dishes from the restaurants they visited. Some people were involved in shopping for food. We observed one person request an alternative to the planned lunch and their request was met. We saw that people were offered a choice of drinks regularly. One relative told us, "Every time I visit the food smells lovely and me and my relative are always offered drinks, there are lots of drinks offered there". We saw that people had access to the kitchen and felt comfortable going in. The registered manager told us that if people wanted to eat and drink outside of mealtimes they were supported to do so. Providing people with a good choice of food and drink assisted them to maintain their health.

We saw that people were weighed regularly and changes in their weight we recorded. Peoples fluid intake was also monitored. Where people were at risk of not eating or drinking enough to maintain their health a risk assessment and action plan was in place. Relatives told us that peoples weight was well managed and

they had no concerns.

People at risk of choking were supported to eat and drink safely. People living at the service had been assessed by a Speech and Language Therapist (SALT). We observed that staff followed the guidance to support people safely. For example, where it had been assessed that people needed adapted cutlery these were available and were used. One staff member was assigned to serve and support each dining table and people were not left unattended whilst eating to reduce the risk of choking.

There was information in place for people to take with them if they were admitted to hospital including health action plans and communication passports. Health action plans are recommended for people with learning disabilities by the department of health to promote people's health and support access to health services. Communication passports are easy to follow person-centred booklets for those who cannot easily speak for themselves when they need to use other services. The registered manager told us that when people were in hospital they would support them to ensure that the person could communicate with hospital staff and were well cared for. One relative told us, "When my relative went in to hospital staff visited almost every day and the registered manager talked to the hospital staff every morning and every evening to make sure that they were being well looked after". When people accessed other services such as the GP or optician staff supported the person to help them communicate and understand and ensure continuity of care.

The staff team knew people well and people's health continued to be regularly monitored. The staff were able to tell us about how they cared for and supported each person on a daily basis to ensure they received effective personal care and support. The staff knew what signs to look out for that indicated that the person was becoming unwell, such as a change in someone's mood or behaviour. When staff had identified that a person was unwell they were aware of what actions to take. For example, when one person's behaviour changed staff suspected that the person had an infection and sought appropriate medical assistance.

People had access to healthcare to maintain their health and well-being. We saw in people's support plans that they had accessed services such as GP, dentists, and opticians. Where needed external support and equipment had been secured promptly and helped people continue to live independently and safely. For example, one person had been supported to access adapted cutlery to enable them to eat safely. Staff had consistently followed peoples support plans. We reviewed the support plan of one person who had been assessed by a speech and language therapist (SaLT). The person had been advised to use an adapted cup to reduce the risk of choking. We observed that they were using this cup and saw photos of the person using the cup out in the community. A relative told us, "When they are unwell or need something staff are quick to react and always get the right the professionals involved".

The environment of the service had been adapted to meet people's individual needs. Two people liked to sit quietly together and two chairs had been moved to an area to enable them to do this. There was a lift within the premises for people who could not use the stairs. People who needed hoists had a ceiling tracking hoist in their bedroom. Bathrooms were adapted and equipped with the equipment they needed such as shower chairs and adapted baths. Peoples bedrooms were personalised with photographs and decorations. People in wheel chairs could move around the service freely and independently and access the garden.

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 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. The registered manager had correctly applied for DoLS within the MCA for people living at the service, but these applications had not yet been authorised by the local authority at the time of this inspection.

Staff we spoke to understood the principles of the MCA and were aware of how to respect people's choices. When important decisions had been made on people's behalf staff had taken part in best interest meetings. Peoples relatives told us that they had invited to be involved in these decisions. Best interest meetings were documented and recorded in people's support plans. Staff had also involved advocates to support people to make their needs known. Advocates support people to express their views and feelings. We observed staff asked for consent prior to carrying out any support tasks. Although people had complex needs, we observed that staff encouraged them to make decisions for themselves. Staff using pictures, objects and gestures to offer people choices such as choices regarding food, drink and activities. For example staff held up a cup to ask people if they wanted a drink.

Good

Is the service caring?

Our findings

People were supported to make decisions and choices based on their preferences and wishes. We observed people being offered choices about food and drink and how they spent their time. One relative told us, "My relative got to do things like going on holiday, out to Café's and going to the theatre. They were doing the things they wanted to do". Another relative said, "Everyone is treated with respect".

A community health and social care professional told us, "It's a lovely home. The staff are extremely caring", "The staff have professional boundaries but still treat people like family".

At our last inspection on 30 December 2015, this domain was rated as outstanding. At this inspection we found that the service had not been able to sustain the outstanding rating. The registered manager told us that the service had faced a challenging year because some people who had lived at the service for a long time had died. The registered manager said, "The last year was challenging, things were quieter but there are plans for new people to move in to the service". The registered manager spoke about the future with enthusiasm and passion spoke of re-energising and new development.

We observed that people were treated with kindness and respect. Staff and the registered manager talked to people kindly and people smiled and had relaxed body language in their company. One community health and social care professional told us, "People tell me that they are happy there and the family have told me that they are happy with the care provided". When speaking to people who were seated, staff bent down and made eye contact. Staff held people's hands or touched their arm. Staff were aware of when people, who could not verbally communicate, needed space and ensured that this was given. Staff observed that one person was at risk of becoming distressed and asked us to move to the other side of the room. Staff told us they had sufficient time to listen to people and spend time with them. We observed staff sitting with people and talking to them. When one person appeared to be distressed staff were immediately aware of this and sat with them comforting them.

People's support plans continued to be detailed, with information relating to their life histories, their preferences, how they liked to receive support as well as how they communicated. Staff told us that they had time to read peoples support plans and could demonstrate to us that they were aware of people how people liked to be supported. A relative told us, "My relative always got their hair cut and coloured. Their nails were always painted. They always wore perfume and smelt lovely. These things were very important to them". Some people communicated using gestures or their own signs. Staff understood peoples individual ways of communicating. We observed that staff discreetly positioned themselves within the communal areas so that they had a line of site and could see people. When people gestured to staff, staff understood and would respond immediately. When we met one person they gestured to the registered manager who told us that the person wanted to touch our hand as a way of greeting. One community health and social care professional told us, "It's amazing how staff have learnt to interpret peoples gestures, they really seem to understand what people are trying to communicate". A relative told us, "All the staff know what my relative is asking for. Instantly they know and respond".

People were supported to be involved in making decisions about their care as far as possible. An advocate visited some people regularly to help them express their views and feelings. Staff promoted personal choice and independence by ensuring that people were involved in day to day decisions regarding their care and support. One staff said, "It's important that we give people as much choice as we can so that they are as independent as possible".

People were given choices in relation to drinks, food and activities and likes and preferences were gauged on people's reactions. We observed that people were supported to carry on an activity until they no longer wanted to do so and staff asked peoples permission before clearing away the items from the activity. People were asked if they wanted their artwork displayed on the wall. When they indicated yes staff asked where they wanted it to be displayed. A relative told us, "If my relative wants to do something or go somewhere they support them to go and do it, there are no restrictions".

The registered manager told us that when people could not express their preference the decoration chosen for their room was based on their personality and the activities and textures they knew people liked. Peoples rooms were individualised and felt welcoming and homely. A community health and social care professional told us, "People are involved in decisions where they can be".

People were involved in the recruitment of the staff that supported them. The registered manager told us that as part of the interview process candidates were invited to meet people. How candidates interacted with people and people's reactions were taken in to account when appointing new staff. People had the opportunity to choose the gender of the person supporting them and this was documented in their support plan.

People's privacy and dignity continued to be protected and promoted. Relatives told us that they were able to visit as often as they wished. People were encouraged to go out with relatives, for example, to go out to lunch. Relatives confirmed that if people wished to remain at home in the service then staff supported them to do so and they were able to visit people in their rooms or in communal areas if they preferred. Staff described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains when delivering personal care and ensuring that people were covered up as far as possible. Relatives told us when they visited staff always asked them to leave the room when they needed to undertake personal care.

Relatives and community health and social care professionals told us that they had seen people become more confident whilst living at the service. People had been living at the service for a long time. Staff told that that they encouraged people to be as independent as possible and to maintain that independence. One person was no longer able to eat an entire meal independently. Staff encouraged the person to do as much as they could for themselves and then offered support when the person needed it. One community health and social care professional told us, "They [staff] encourage my client to get involved and to help out in the garden". Another community health and social care professional said, "My client wouldn't socialise at all but now they greet me and takes my hand".

Peoples personal information was protected. We saw that people's records were stored securely so that personal information remained confidential. The staff we spoke to understood the importance of protecting peoples confidentiality. Information was available in accessible formats for people. Where people could not understand this information staff took the time to explain the it to them.

Good

Is the service responsive?

Our findings

A relative told us, "When we go out with [my relative] everyone in the community knows them and stops to say hello".

One community health and social care professional told us, "They drop everything and take my client out when she wants to go", "People in the community know my client as they are always out and about".

We observed that staff were responsive and flexible to people's choices and needs. Support plans were person centred and comprehensive, with every area of the person's life broken down into sections. For example, activities, decision making, personal care. These sections were broken down further. For example, for each area of someone's life there was information on what support they needed to make decisions. There was a section to describe what a good day would be for each person which described all aspects of their care and support. People support plans included goals and aspirations. Peoples plans were reviewed regularly. Staff and community health and social care professionals confirmed that people were involved in the review of their plans as much as possible. Relatives told us they had a say in how care was planned and provided.
When there changes to people's preferences, likes and dislikes these were discussed at the staff handover and documented in the handover notes

People participated in leisure activities, for example going to out to dinner, attending community events and personal shopping. Key workers were allocated to people's activities based on their skills, experience and where possible shared interests. A key worker is a person who takes the overall lead for that persons support. Activities that people enjoyed were recorded. This meant staff could understand and meet people's individual needs.

The activities people were involved in were tailored to their preferences to encourage participation and reduce social isolation. Some people had one to one activity sessions, others had routinely been out to a social club, attended events and visited places that may interest them. For example, walks to the beach and attending the local carnival. The registered manager told us that some people liked shopping for clothes but found it difficult to access some shop because the isles were narrow and the clothes often high up. The registered manager arranged for a clothes shop to visit the service every three months to put on a fashion show. Staffing was provided based on the assessment of risks the activity to be undertaken may have. Activities were introduced to people slowly so that staff learn by the person's responses if they were comfortable with the activity. If people did not enjoy an activity staff would try another approach. A relative told us, "They are brilliant with my relative, they do respect their wishes. If [name] doesn't want to do anything they work with her and try other things".

People had not had cause to complain. The relatives we spoke to told us that they were happy with the service and had not made any complaints. However, the provider had a comprehensive complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was made available in the service. For people living in the

service, the staff used analysis of behaviours and reactions such as body language to gain information about people to gauge what had made them unhappy and why. Any concerns were recorded in people's support plans and discussed at hand over meetings. A community health and social care professional told us, "The staff are good at listening to and observing people. When they think there is a problem or the person is unhappy they really try to analyse what's going on and deal with the cause of the problem".

The service was not currently supporting anyone at the end of their life, however they had done so in the past. The registered manager told us and relatives confirmed that there had been discussions about people's wishes when they needed end of life support and these had been recorded. When people had died other people and their relatives were provided with emotional support. People, staff and relatives were invited to attend a wake to celebrate the person's life. When we spoke to relatives they were positive about the way staff had supported people and their family before, during and after a person's death. One relative feedback to the service and said, "The support through this difficult time was amazing". Another relative told us, "They really looked after my relative, they couldn't have done more. They have supported us emotionally, they were brilliant".

Good

Is the service well-led?

Our findings

Staff, relatives and community health and social care professionals told us that the service was well-led. A relative told us "The registered manager is brilliant, she always seems to know what to do and who to inform". Another relative said, "I think the service is well managed. The registered manager is very on the ball. The registered manager and staff keep each other informed". Staff told us that they enjoyed working at the service and some staff had worked there for a long time. One staff said, "I feel really supported, we look after each other".

A community health and social care professional told us, "The registered manager is very good and the staff are extremely caring". Another told us, "The service is very well-led. The registered manager is always talking to people and has really good relationships with the people who live here".

The service continued to be well-led by a skilled and enthusiastic registered manager. The registered manager had been in post at the service for 16 years and was experienced in working with people with learning disabilities. They were supported by a deputy manager and other senior staff who had also worked there for a long time. A community health and social care professional told us, "The staff team is very stable".

The registered manager had a clear vision for the service which was based on person centred support and promoting a positive culture and environment. Staff were aware and understood the vision and values of the service. Staff told us, "Everyone is treated as an individual". Another member of staff said, "I really feel like I have built relationships with people here, it feels like a family", "People are supported to have a say and a choice and as have as much independence as they can".

There continued to be a positive culture and atmosphere between the registered manager, staff and people. The staff we spoke with were positive about the service and told us that they enjoyed their role. Staff were clear about their roles and responsibilities and who their manager was. Staff treated each other with respect and spoke highly of one another. The registered manager spoke highly of the staff. The registered manager said, "The staff here are passionate about their role and the work we do".

Staff told us that the registered manager was accessible and approachable and that there was an open door policy. Staff had regular supervisions, appraisals and observations with the registered manager, and told us they felt supported in their role. The registered manager told us that they expected staff to deliver support of a high standard, with passion and kindness. The registered manager worked alongside staff on a daily basis and was therefore able to review and understand staff practice. Appropriate procedures were in place for investigations, staff grievances and disciplinary matters.

Policies and procedures continued to be updated on a regular basis to ensure they reflected current legislation and were available for staff to read. Staff were expected to read these as part of their training and induction.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

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 that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating at the service and on their website.

The registered manager and provider shared information, and was transparent about the future of the service. The registered manager told us that they kept in regular contact with peoples relatives and invited them to feedback on people's support and the service thought the year. Relatives confirmed this. Feedback was consistently positive. One relative told us, "We are very pleased with the care and support [name] is getting.", Another relative said, "[name] is getting the best of care, it comes from the heart". Relatives told us that the registered manager actively kept them informed about developments to the service. A relative told us, "The registered manager is approachable. We always interact with the registered manager and I am always kept informed".

There were staff meetings every three months. There were also regular meetings for staff who worked at night and could not attend during the day. We saw minutes of meetings held, and the staff we spoke with confirmed that they took place. Any issues or ideas staff had were discussed in their team meetings, supervisions. Staff told us they felt comfortable raising issues and ideas with the registered manager. Staff told us, "We all get to have our say and contribute ideas and opinions".

Staff, relatives and community health and social care professionals told us that there were strong links with the local and wider community and people were well known in the community.

The service continued to monitor the quality of service provided. People, staff and their relatives were invited to provide feedback annually via questionnaires. This helped the service to understand what they thought of the service and where improvement was needed. Questionnaires for people were in easy read format and people were supported by their keyworker to complete these. Feedback from the questionnaires was positive.

Checks and audits continued to be completed on all aspects of the service. The registered manager and deputy manager audited aspects of care such as medicines, support plans, health and safety, infection control, fire safety and equipment. The head of operations, who was the providers' representative, visited every four months to check that all audits had been carried out and supported the registered manager and the staff team to make sure any shortfalls were addressed. The company's quality auditor continued to make visits yearly. The last visit had been in October 2107. A financial audit was undertaken in August 2017. The service continued to use the Care Quality Commission (CQC) methodology as a guideline for the audits and checks to ensure compliance with legislation. The registered manager told us that they felt supported by the provider and that resources were available for development and improvements.

The registered manager had an oversight of accidents and incidents. They regularly reviewed information to see if changes to people's support was required due to people's changing needs. For example, one person had had a fall. The persons support plan had been reviewed and action plan was in place to reduce the risk of reoccurrence.

The registered manager continued to worked closely with social workers, referral officers, occupational therapists and other health professionals. The registered manager told us that they attended local forums to share and develop best practice. One community health and social care professional told us, "They always contact me if anything is needed". Another community health and social care professional told us that they visited the service regularly.