Link-Ability

St Mary's Gate Euxton

Inspection report

25 St Mary's Gate
Euxton
Chorley
Lancashire
PR7 6AH

Tel: 01257241899
Website: www.linkability.org.uk

Date of inspection visit:
21 March 2018

Date of publication:
25 May 2018

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?	Outstanding ☆
Is the service well-led?	Good

Summary of findings

Overall summary

St Mary's Gate is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, both of which we looked at during this inspection supporting four people living with profound learning disabilities and complex needs. At the time of this inspection, there were three people living at the home.

St Mary's Gate is located in a residential area of Euxton near Chorley. The home is within easy reach of the town centre and transport links can be accessed without restrictions. The home has living accommodation, a large dining area, a domestic kitchen and utility room used as a laundry. The home has four suitably adapted bedrooms and a bathroom. The home is a bungalow so access is only required to the ground floor level.

There was a registered manager for the home. 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 the last inspection on 22 December 2016, we found that the provider needed to take action to ensure the people in the home were protected in the event of a fire, and that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection in March 2018 we found that following a visit from the Lancashire Fire and Rescue Service and discussions with the housing landlord, improvements to the fire safety system had been made, and the service was no longer in breach of the regulation.

At the last inspection on 22 December 2016, we found that the provider needed to take action to ensure the people in the home were protected at night as there was only one member of staff on duty. Immediately after the inspection, the night time staffing arrangements increased. This ensured people were now better supported as some of the care they received requires two members of staff.

People who used the service received an excellent personalised service that met their individual needs and preferences. People were at the centre of how their service was run and were fully involved in the planning and developing of the service. Staff used innovative ideas and actions to improve people's quality of life and to give them outstanding opportunities in daily life. People were supported with meaningful activities which supported their well-being and encouraged them to access the local community.

The provider had effective systems in place to ensure there was always the correct amount of staff with the appropriate skills and training needed to provide safe care for people. There was a structured induction program to ensure staff developed the skills needed to work for the provider and on-going training was in place that ensured staffs skills remained up to date. Staff were provided with support from their line

manager to ensure they were working in line with best practice. Recruitment processes ensured staff were safe to work with people at the home.

Risks to people were managed and care was planned to keep people safe. The registered manager had submitted appropriate applications under the Deprivation of Liberty Safeguards (DoLS) to ensure people's human rights were protected. People's abilities to make choices were respected and where needed decisions were made in people's best interests. Risks to people were identified and appropriate action taken to keep people safe.

People's medicines were available to them when needed and stored safely. Appropriate support was provided, and advice taken to ensure that people's nutritional and hydration needs were met.

Staff were kind, caring and knew how to personalise care to meet people's individual needs. They respected people's privacy and dignity and people's achievements were celebrated. Staff understood people's communication needs and supported them to make their views known. People's personal environment had been decorated to reflect them as an individual and the care they needed.

Staff ensured that people's needs were assessed and care plans reflected their individual needs and were updated when people's needs changed. People and their relatives had been involved in planning their care.

Relatives were able to raise concerns and the provider took action to improve the care they received. People's views (where possible) about the quality of care they received were gathered and used to drive improvements in care. Additionally people were involved in the running of the home and their views were taken into account when recruiting staff or making changes.

The provider had effective systems in place to monitor the quality of care people received and took action when any concerns were identified. Staff felt supported and were encouraged to develop.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to keep people safe from abuse.

Risks to people were identified and plans put in place to keep people safe.

Systems in place ensured that there was always enough staff to meet people's needs.

Medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff received effective training and support which enabled them to provide safe care.

People's rights were protected under the Mental Capacity Act 2005.

People were supported with appropriate food and drink to stay healthy.

Staff supported people to access healthcare when needed.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and understood people's needs.

People's privacy and dignity were respected.

People were able to make choices about their everyday lives.

.

Is the service responsive?

Outstanding

The service was extremely responsive.

People who used the service were at the centre of what staff did to support them.

Staff used innovative ideas to support people to experience an excellent quality of life dependent on their individual needs and preferences.

People's needs were assessed before they moved into the service and their transition to the service planned to support them through the change.

Care plans reflected people's needs and described how care could be tailored to meet people's individual needs.

People were supported to access activities and to maintain hobbies and interests.

Complaints were dealt with in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

People were supported to be involved in the development of the home and their views about the care provided were respected.

The provider had effective systems in place to monitor the quality of care provided and systems in place to take proactive action to resolve issues.

There was a culture of continuous improvement and the provider ensured they kept up to date with changes in best practice.

St Mary's Gate Euxton

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 21 March 2018, and was unannounced. The inspection team consisted of one adult social care inspector.

Before our unannounced inspection, we checked the information we held about the home. This included notifications the provider sent us about incidents that affect the health, safety and welfare of people who lived at the home. We also contacted other health and social care organisations such as the commissioning department at the local authority. This helped us to gain a balanced overview of what people experienced living at the home.

We looked at the Provider Information Return (PIR) the provider had sent us. 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 used a planning tool to collate all this evidence and information prior to visiting the home

We spoke with three staff members, two relatives and one visiting social care professional. We spent some people observing the care and support provided to people to help us understand the experience of people who could not talk with us. We observed care and support in communal areas and looked around the building to check environmental safety and cleanliness.

We also spent time reviewing records. We examined care records of all three people who lived at the home. This process is called pathway tracking and enables us to judge how well staff at the home understand and plan to meet people's care needs, and manage any risks to people's health and wellbeing. We checked the recruitment, training and support documents in relation to three staff members. We also looked at records related to the management and safety of the home.

Good

Is the service safe?

Our findings

The people living at the home did not communicate with others verbally, so we spent some time observing people, and looked at their engagement with the staff, and how the staff interacted with them. Our observations were that people appeared to be comfortable around the staff. Staff spoke to people in a positive manner, and were fully aware of safety issues such as individual health concerns, safe moving and handling and choking risks.

We spoke with some of the parents of the people who lived at the home, and everyone we spoke with was positive about the service. One relative said, "I'm very happy with the care provided, and I have no concerns over safety."

At the last inspection on 22 December 2016, we found that the provider needed to take action to ensure the people in the home were protected in the event of a fire, and that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection in March 2018, we found that following a visit for the Lancashire Fire and Rescue Service and discussions with the housing landlord, improvements to the fire management arrangements had been improved.

A fire risk assessment had been completed and following this, the landlord had installed an upgraded detection system, to give better warning in case of a fire. We saw the fire alarm was tested weekly. Fire doors were now held open magnetically, and this mechanism was linked to the fire alarm system. Upon activation of the alarm, the fire doors would close.

At the last inspection on 22 December 2016, we found that the provider needed to take action to ensure the people in the home were protected at night as there was only one member of staff on duty. Immediately after the inspection, the night time staffing arrangements increased. The service now had one waking night staff and one sleeping night staff who could be woken if needed to support and care for people in the home. This ensured people were now better supported as some of the care they received required two members of staff.

We looked to see how the service ensured that people were kept safe, and protected from abuse. We found that staff received training in safeguarding vulnerable adults, and our discussions with staff showed that the service had well established relationships with the local safeguarding team operated by the Local Authority. Staff were aware of how to report safeguarding issues and concerns, and had a good understanding of potential abuse which helped to make sure that they could recognise signs and symptoms of abuse.

The registered manager was found to investigate (when asked by the Local Authority) and review incidents in an open and transparent way. Whistleblowing procedures were in place, and staff knew how to use them. Evidence held within the service records showed that incidents, accidents and safeguarding concerns were reported promptly, and, where required, thoroughly investigated.

We looked to see how risks were assessed in order to maintain people's safety. Risk assessments and risk management strategies were in place for all people living at the home. These were regularly reviewed, and if changes were needed then these were swiftly implemented in order to ensure people's safety was promoted and protected.

Risk assessments provided staff with guidance on how to manage risks in a consistent manner and included for example moving and handling, use of bed rails, tissue viability, nutrition and emergency situations such as choking or dealing with epilepsy. Restrictions were minimised so that people felt safe but also had the most freedom possible, regardless of disability or other needs. Risk assessments were found to be proportionate and centred round the needs of the person.

There were strategies in place to make sure that risks were anticipated, identified and managed. Where the service was responsible it kept equipment serviced and well maintained. The staff and management team took action to reduce the risk of injury caused by the environment people lived in and looked for ways to improve safety.

Environmental risk assessments and health and safety checks were completed and kept under review. These included for example, regular checks in relation to fire, health and safety and infection control. Emergency evacuation plans were also in place including a Personal Emergency Evacuation Plan (PEEP) for each person living in the home. The home had a contingency plan in place for use in the event of a major incident.

We looked to see how suitable staff were recruited to work with people. We found documentary evidence to show recruitment systems were robust and made sure that the right staff were recruited to keep people safe. All of the proper pre-employment checks were seen to be carried out in a timely manner, and new staff were shadowed by established staff whilst on their induction.

Proper checks had been completed before staff began working for the service. These included the receipt of a full employment history, an identification check, written references from previous employers. As well as a physical and mental health declaration and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

We looked to see how people's medicines were managed, and how the systems in the service protected people for the misuse of medicines. Our observations, the records and audits showed that staff stored medicines correctly, disposed of them safely and kept good records. Staff spoke knowledgeably regarding medicines management. They confirmed that they were trained appropriately, had the necessary assistance from management and were competency checked regularly. The staff records confirmed this.

Correct procedures were in place to ensure that regular discussions with GPs and Social Workers took place, and that decisions relating to medicines were appropriately recorded. This helped to ensure the risk of errors relating to administration of medicines was minimised.
The staff explained how they managed the control and prevention of infection. Staff followed policies and procedures that meet current and relevant guidance. Staff understood their role and responsibilities for maintaining high standards of cleanliness and hygiene.

Staff told us that there was a culture of learning from mistakes and an open approach. No specific examples of learning from incidents were given. However the registered manager explained that due to the small number of people living at the home, staff were in a position to constantly monitor people's situations and

other's practice, and pick up on issues very quickly, and modify their practice accordingly.

Good

Is the service effective?

Our findings

The registered manager explained that she made sure the needs of people were met consistently by staff who had the right competencies, knowledge, qualifications, skills, experience and attitudes. We saw records that showed staff had a thorough induction which gave them the skills and confidence to carry out their role and responsibilities effectively. The service had a proactive approach to staff members' learning and development.

All supporting staff were provided with an appropriately paced induction to ensure the new staff member was introduced to the person/people they will support at a pace the person was comfortable with. New staff were not engaged in complex health interventions until trained and deemed or assessed as suitably competent.

Staff received high quality training and competency assessment in all aspects of the physical and psychological needs of the people being supported. This included postural care training, relevant medical/health training and mental health awareness training. The registered manager ensured that staff had a thorough understanding of the significance and impact of common health conditions on the health and mortality of people with profound and multiple learning disabilities.

All support staff received regular in-house and external training, updated and reviewed at appropriate intervals, such training included total communication, manual handling of people, postural care, intensive interaction or sensory engagement, active support, safe eating and drinking skills, supported choice and decision making. There was evidence that the specific mandatory training provided was dictated by the needs of the people being supported and the risks to their wellbeing. Following staff training competency checks and questioning sessions were completed by the registered manager. These covered multiple areas including personal care, infection control and the MCA. Staff we spoke with said the provider supported them with a range of courses.

We found evidence staff received regular supervision to underpin their roles and responsibilities. Supervision was a one-to-one support meeting between individual staff and the registered manager to review their role and responsibilities. The two-way discussion covered, for instance, a review of previous sessions, work performance, training and personal issues. The registered manager explained staff were asked questions around equality and diversity during their supervision and appraisals, and this was documented in the staff files.

People's needs were assessed before they moved into the home. Assessments were fully completed prior to people being considered for a move to the home. The records showed that people's needs and care plans were regularly monitored and reviewed and relevant professionals and their relatives were actively involved in this process. Everyone who lived in the home was supported with the use of a Percutaneous Endoscopic Gastrostomy (PEG). This is a tube that is inserted directly into the stomach to support people with their nutrition, hydration and medication.

In addition to this, some people had been assessed as being able to tolerate small amounts of food and hydration. We reviewed the information held in people's care files and found that support plans were specific to the needs of the person and included the use of the PEG in varying degrees. Risk assessments were developed to support people when they were receiving tastes or types of food to reduce the risks of choking.

People were supported to maintain their health and emotional wellbeing through access to preventative healthcare, for example GP visits, dental checks, opticians and chiropodists and had annual health checks and medicines reviews. Staff knew people's routine and specialised health needs and preferences, and the records showed that these were consistently kept under review.

Appropriate referrals were made to other health and social care services as and when required. People who lived in the home had been in receipt of support from services most of their lives and as such had transitioned from child to adult services. Family were heavily involved with each person who lived in the home and were involved with developing and agreeing to the care and support provided.

The home was accessible to people and pleasantly decorated, and had adaptations to meet people's current needs. There were ramps and mobility aids.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 who lived in St Mary's Gate had limited capacity and each person was living with complex needs, including some limitations with their mobility. We saw people's mental capacity to consent to their care had been assessed and when people lacked the capacity to agree to specific care and support, the principles of the MCA were followed. People's care and support plans were clearly developed within the principles of the MCA and we could see assessments and decisions had been made. For example, the people using the service had been assessed as not being able to agree to move to a new home, and we saw that a best interest meetings had been held with all the relevant care agencies and relatives who supported the person and a decision made in the person's best interest.

We saw support plans, policies and procedures and risk assessments were all shared with staff and staff signed to say they understood them and could follow them. We also saw that the competency of staff was tested to ensure they were following the guidelines and plans. Each person was predominantly supported with their mobility by a specially adapted and personalised wheelchair. People could not leave the home unattended and relied on staff for support in all aspects of daily living, including meeting their social and emotional needs.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had applied for DoLS authorisations for each person who lived in the home.

We reviewed the available assessments to support the applications. Decision specific assessments had been completed including the appropriate best interest decision. Best interest meetings had included

appropriate professionals and family members and had involved the individual preferences, as much as practically and safely possible to do so. It was clear staff had a good understanding of the requirements under the MCA.

It was clear that the home was operating within the parameters of best practice. The service had been developed and designed with the people in mind, and family members had been, and continued to be involved in the operation of the home. The service was located in a residential area, and this enabled people to live and shop locally. Family members were able to visit easily, and people at the home were able to travel to visit friends and family, sometimes on a daily basis. The location of the home enabled people to participate in their own local community and they had easy access to the health and social care services used by the local community.

Good

Is the service caring?

Our findings

Staff spoke to people in a kind and respectful manner. They were professional in their approach whilst also ensuring there was 'a sense of fun'. We saw many positive interactions with people clearly enjoying the company of staff. Interactions between staff and people in the home were meaningful and included staff taking people around the home as it was cleaned, as food was prepared and as laundry was undertaken. Families told us staff at the home ensured their families experienced a good quality of life.

People who lived at the home were part of the local community and participated in it. Staff supported people to use local facilities such as buses, shops and banks, and family members believed this was done in a way that was caring, and promoted people's rights to participation and inclusion within society.

The atmosphere in the home was calm and relaxed. This was particularly important given the complex needs of people. Considerable care was taken to synchronise people using communal corridors and doors, particularly when people were anxious or upset.

People who lived at the home were seen to be well presented. People's hair was styled and clothes they wore showed a sense of individuality and preference. Staff had a very good knowledge of the people they supported, including their life histories, the things they liked and didn't like and who was important to them. Relatives and friends were welcome to visit at any time and people were supported by staff to maintain relationships with friends and family outside of the home.

Staff took note and recorded specific important family events, including birthdays and anniversaries. Staff took people from the home to the shops and purchased gifts from them for their family members at these special times.

Each person had a communication plan which identified how and why people in the home could or would react to certain situations. The plans included prompts and signs of emotive states, such as happiness and anger. Plans included likes and dislikes and identified the person's favourite objects linked to the objects of reference framework for communication. As people in the home could not verbally communicate they were not able to give their verbal consent. The three people who used the service were assessed as lacking the capacity to always consent to support. Every interaction we saw in the home was undertaken with dignity and respect.

Staff worked hard to deliver the support people needed, whilst respecting the wishes of those they were supporting. Staff were aware of how people communicated their health needs, including indicators of discomfort, pain or distress. Details with people's records showed that staff were effective in responding to these communications by supporting people to feel comfortable.

Staff had developed the 'object of reference' tools to allow people in the home to show approval or not, to interventions and support provided. This was also used to reduce anxiety in the support provided. By showing an object of reference, for example a toothbrush prior to supporting someone to brush their teeth,

allowed the people being supported the opportunity to show approval or not. Staff could then proceed to support the person with brushing their teeth or not.

Advocates were used (as required) to assist people in making important decisions. An advocate is independent of social services and the NHS. and their role includes arguing people's case when they need them to, and making sure the correct procedures are followed by service providers, health and social care services.

People's care plans showed care had been taken to involve them and their families in the planning of their care and support. Promoting people's independence was a theme running through people's care records. People's preference in relation to support with personal care was clearly recorded. This included detailed routines for providing care in the morning and evenings and whilst engaging in different activities. The approach required from staff was also clearly recorded and understood. For example, one person did not like there to be too many people in their room, others did not like staff to be too loud. Staff we spoke with understood people's preferences and said they adapted their approach accordingly.

Outstanding ☆

Is the service responsive?

Our findings

The relatives we spoke with told us they had total confidence in the work of the staff as they were seen to be skilled and knowledgeable, and able to provide care and support that was responsive to the needs of the people who lived at the home. One person said, "Staff know how to meet my relative's preferences and are great at coming up with ideas as to work with and support [name]. I think this means that [name] has an enhanced life and their quality of life is fantastic."

One social care professional with we spoke said, "If you think of outcomes, then the service gets great 'results'. People are supported to get out and about, participate in the community, they are included as much as possible about decision making, they are valued, their complex health needs are met and their rights promoted and protected."

Staff we spoke with showed an exemplary value base. Staff were seen to very caring, person centred and enabling. We observed the daily routines and practices within the home and found people were treated equally and their human rights were constantly being respected. Equality and diversity issues were consistently considered, and people's rights to take part in the local community, make (limited) decisions and live a fulfilling life were promoted.

The registered manager explained that the main job of the staff was to proactively respond to the assessed and changing needs of the people living at the home. She said, "Each individual all had great difficulty communicating, often requiring those who know them well to interpret their responses and intent. They also have other, additional needs such as physical disabilities, sensory impairments, sensory processing difficulties, complex health needs, [e.g. epilepsy, respiratory problems, dysphagia and eating and drinking problems] and sometimes mental health difficulties."

One person at the home was found to use SKYPE on an iPad, on which they communicated with their family on a weekly basis. The iPad was also used to play games on, and the person got lots of enjoyment from this especially from the encouragement from staff.

The Registered Manager explained the past, the service had trailed the use of buttons that could be used to turn on and off electrical items, eg television, radio. But unfortunately due to the limited capabilities of the people who used the service, their use was unsuccessful, as people were unable to comprehend the outcome of their actions. If any new admissions to the service were to be considered, then the use of technology would be part of the assessment and care planning process.

Our observations, record checks and discussion with relatives and staff showed that the people living at the home were extremely well supported to lead meaningful lives despite the fact that they required high levels of support with respect to all of their activities of daily living. Although not medically trained, the staff demonstrated an in depth specialist knowledge of people's healthcare and communication needs to respond to people, and support them to receive personalised care and support.

People's needs were assessed before they moved into the service and their transition to the service planned to support them through the move. People were assessed before they moved into the home and given information about how the provider could support them. One person's relative said, "I had lots of information given before [name] came to the home."

The level of detail in the assessments meant that people were more likely to have a smooth move into their new home. For example, people's communication needs were reviewed to ensure that staff could understand them. People and their relatives were involved in planning and reviewing the care that they received. One person's relative said, "We are involved in the planning, and staff listen. We discuss any changes and have asked for changes ourselves."

We found care plans were extremely comprehensive and provided very clear information about people's daily support needs. There were well detailed protocols in place, which provided step by step guidance for carers in how to support people to carry out activities of daily living such as bathing, dressing and meal preparation. Some, such as those in relation to moving and handling, included clear photographic guidance of people's mobility equipment.

Each person with limited movement had a thorough postural care management plan in place with input from physiotherapy and occupational therapy. Plans included seating arrangements, night and daytime positioning systems, any medication prescribed to assist with postural care, the use of equipment e.g. wheelchair, standing frames, orthotics, pressure relieving equipment. Staff were clear that promoting good posture had appositive impact on people as it allowed muscles to work more efficiently, prevented tiredness, and reduced the possibility of back and muscular pain. One staff member said, "If we promote good posture then it has a knock on effect of people's frame of mind which can only be a positive thing."

Staff had a thorough awareness of what was 'usual' for people in terms of their health and wellbeing, and were able to identify and respond swiftly to indicators of changes in health status (physical or psychological/emotional and mental health). Staff were aware of how people communicated their health needs, including indicators of discomfort, pain or distress. Details with people's records showed that staff were responsive to these communications. For example, staff had spent time in paying attention to one person's movements and vocalizations, and saw them all as possible attempts at communication. By keeping a running record, and getting to know the person, staff had been able to build up a picture of the people's communication traits, and used this to check that they were happy or sad, comfortable and engaged in a task.

Staff explained that there were times when people's ability to communicate could led to frustration, and so very detailed and positive strategies had been put in place to respond to this. The strategies included guidance for care staff in how to provide positive, consistent support during challenging situations. We saw that care staff and family member had been involved in the development of the strategies to ensure they understood and agreed with them. For example, by using visual clues, a gesture, or objects of reference staff were able to identify areas of conflict, and reduce people's anxiety and frustration.

Each person at the home had a health action plan and communication passport which was always available when people went out into the wider community. This key information would enable other professionals to have all the information they needed to be able to meet the needs of the individual in the event other services were required. This included details of hospital admissions and medication, how the individual displayed pain and details of their current medical conditions.

Staff demonstrated timely and early intervention to prevent escalation or in response to all health concerns

by the routine monitoring of an individual's holistic health. Guidance for staff on supporting people with their physical and mental health was detailed and comprehensive and supported excellence in the delivery of care. For example, plans to support people with complex epilepsy and plans to support people to express their frustration were in place. They also contained important details about people that hospital staff should know when providing treatment. This information helped to ensure that people received the support they needed if they had to leave the home in an emergency.

Staff were clear that when a person was admitted to hospital, a copy of the medicines record, their medicines and the hospital passport would be shared with hospital staff. They also demonstrated their commitment to ensure people were supported in the best possible way if they were admitted to hospital by ensuring the Learning Disability Liaison nurse based at the hospital was included in the admission process. Staff told us that some people did not particularly like hospitals and staff would support them during their stay with regular visits.

Staff said, "Having a hospital passport is really useful, as it gives hospital staff helpful information about the person that isn't only about their illness and health. It helps hospital staff get to know the person, and that means the person can feel comfortable in an unfamiliar place. It also means that as a staff member, we don't have to constantly talk about and repeat personal information about the person as it is all recorded. This makes medical appointments and hospital visits more dignified."

Staff were committed to ensure people's health needs were met. People were supported to access a wide range of health and social care professionals to meet their needs. These included an annual health check with the GP, speech and language therapy, psychology input, occupational therapy and physiotherapy.

People's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals when required. Staff confirmed any changes to people's care was discussed regularly at team meetings or through the shift handover process. Staff told us that handovers at shift changeover was important, as it "ensured that all staff were aware of any changes to people's care needs and to ensure a consistent approach."

We reviewed the electronic and paper records used to identify how the home were supporting people. We saw there were mostly electronic records for the support plans and assessments of people's needs. Support plans were developed with the family and where relevant the social worker or other professionals involved in people's support. Plans were comprehensive and person centred in their approach to delivering services.

We saw bespoke plans had been developed which provided guidance and support for people's daily living needs as well as the care and support needed to support people's life experiences. Topics covered included relationships, leisure, cultural and spiritual needs, emotions and decisions. All support areas were linked to outcomes, such as I want to enjoy new activities. Routines and social habits were built into outcomes to ensure people got the best from any support provided.

The registered manager explained that for the people living at the home, understanding the concept of end of life care would be limited due to their capacity. However, this was discussed with relatives, and their responses to this sensitive issue was recorded within people's care plans. Care plans contained information on people's, and their families, wishes in the event of their death. This included people to contact and information on any funeral arrangements made or any individual wishes expressed by the person, and/or their families.

People were supported to access activities and to maintain individualised hobbies and interests. People's

care and support was planned proactively in partnership with them. Staff used innovative and individual ways of involving people so that they were consulted, empowered, listened to and valued, despite their complex needs. People were found to be consulted about the nature of their support during "Link up" meetings held every three months. Each person from the service was found to invite their family and advocates, and time was spent looking at the care provided in terms of "What's working", "What's not working" and "What needs to change". This took considerable care and planning as people using the service were not able to express their views and opinions verbally, so the close observation of body language and non-verbal cues was necessary.

Staff members worked together as a circle of support around each person. Planning meetings were held regularly and focussed on the person. These meetings covered areas such as, their health and social and leisure activities. The meetings gave a platform for each person to have their needs presented and responded to. We saw assessments completed with families and professionals that looked at individual's perspectives and needs including holidays and time spent with other people outside of the home.

Staff recognised the need for everyone to participate and be actively engaged in activities, and had proactively responded to this need. Staff sought out services that provided fun activities and enabled people to take part in activities would be seen to be only accessible to fully mobile people. For example, attendance at public sessions at Chill Factor and dance events at the Manchester Arena. Everyone at the service had their own vehicle specially adapted to their needs. We noted a number of different activities noted in the staff communication book, including support needs for people in the home, appointments to be made and one item of equipment that needed to be repaired. We tracked each activity through the records of the home and could easily ascertain the details and completion of all activities.

The home always ensured there was an available driver for each person. People were supported to access specialist services that provided numerous activities including, ice skating, horse riding, skiing and trampolining for people restricted to wheelchairs or those who required hoisting equipment to keep them upright.

Complaints were dealt with in line with the provider's policy. The home had a positive and transparent approach to complaints. Any complaints received were managed in line with the provider's complaints policy. A relative said, "If I have any concerns, everything is open and transparent; I never have any complaints and I can talk to the staff at any time about anything that I might be concerned about."

An easy-to-read document was used to good effect and people's concerns were captured effectively with clear explanations given as to how the matter would be resolved. The registered manager saw complaints and concerns as an opportunity to drive improvement. A comprehensive record of all complaints, from the initial problem and the eventual solution were captured and recorded. The outcomes of complaints were recorded, and then communicated to staff at staff meetings so that lessons could be learnt.

Good

Is the service well-led?

Our findings

All the staff in the home were positive and passionate about the service and the people that live there. This was reflected in how well they knew people's needs and how they had supported, protected and encouraged people to live well and be the best they could be. A member of staff told us, "I love working here."

People, particularly families and external professionals were supported and encouraged to be involved in the development of the service and their views about the care provided were respected. We found a positive approach to sharing information with and obtaining the views of staff, people who use services, relatives, external partners and other stakeholders. Staff meetings took place regularly and people were encouraged to share their views and ideas for improving the service.

All the families we spoke with were heavily involved with the care provided at the home. One relative told us, "We couldn't have provided this level of support and access to activities and social life". People's key workers met regularly with families in link up meetings. This was an opportunity for people to discuss, what was going on in people's lives, any issues or concerns and how these could be resolved. The meetings also discussed anything additional families would like to see in the home or in particular to their daughter's care.

The provider had effective systems in place to monitor the quality of care provided and took proactive action to resolve issues. The leadership and governance systems were found to promote good quality care based on the assessed needs of people living at the home. Quality assurance processes now ensured that any risks or shortfalls in care were identified and dealt with in a timely fashion. Governance and performance management were reliable and effective. Systems were regularly reviewed, and risks were identified and managed. Staff completed on-going checks as part of their daily tasks to ensure people received the care they needed.

The registered manager and senior management team undertook a range of audits to ensure staff were providing safe and good quality care. Any actions were identified and completed. Feedback to staff was described as consistent and this meant that any instructions were clear about what was needed to bring about improvements and lessons learned identified. Policies and procedures were in place for staff to follow, and these were periodically reviewed to ensure staff had up to date guidance which was in line with national guidance and good practice.

The home had a consistent staff team at the time of the inspection and the registered manager, staff and families acknowledged the importance of a consistent team when working with people with complex needs. Everyone we spoke with shared a mutual respect of each other and of the service provided to the ladies who lived in the home.

We also saw regular meetings for people lived at the home, which shared information important to people from the care provider (Linkability)

There was a culture of continuous improvement and the provider engaged with external consultants to ensure they kept up to date with changes in best practice. The registered manager at the home was registered with the CQC. Staff were very complimentary about her and her approach. She was described as "visible and approachable."

Staff explained there was an open and transparent culture within the home which helped them share ideas and raise any concerns. Staff felt supported by the registered manager and senior management team, and they said that there was a good team approach to work in the home.

Staff told us that communication in the team was effective. They had a handover meeting so that staff coming on shift had up to date information about people and any incidents or changes to their care needs. There was a written copy of the handover so staff could refer to it, and a shift plan with allocated duties to be completed throughout the shift which ensured staff understood their responsibilities and the home ran smoothly.

The service had a collaborative and cooperative approach to working with external stakeholders and other services. Visiting healthcare professionals confirmed that the registered manager and staff always shared information effectively and appropriately. Data relating to people living at the home was shared as required with eternal agencies and this helped to showed there were good systems in place that promoted partnership working.

There were systems in place to ensure the CQC rating given to the home was displayed e.g. the provider's website, and on the noticed board within the home. The manager notified CQC of incidents such as safeguarding alerts, as required by law.